

AMENDED IN SENATE JUNE 27, 2011

AMENDED IN ASSEMBLY MAY 24, 2011

AMENDED IN ASSEMBLY MAY 10, 2011

AMENDED IN ASSEMBLY MARCH 29, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 1083

**Introduced by Assembly Member Monning
(Principal coauthor: Assembly Member Feuer)**

February 18, 2011

An act to amend Sections 1357, 1357.03, 1357.05, 1357.06, 1357.07, 1357.12, and 1357.14 of, and to amend, repeal, and add Sections 1357.15, 1357.50, 1357.51, and 1357.52 of, the Health and Safety Code, and to amend Sections 106, 10700, 10705, 10706, 10707, 10708, 10709, 10714, and 10716 of, and to amend, repeal, and add Sections 10198.6, 10198.7, 10198.9, and 10717 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1083, as amended, Monning. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, imposes various requirements, some of which take effect on January 1, 2014, on states, health plans, employers, and individuals regarding health care coverage. Pursuant to the requirements of that act, existing state law establishes the California Health Benefit Exchange for the purpose of, among other things, making available qualified health plans to qualified individuals and employers, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health carriers by the Department of Insurance. Existing law provides for the regulation of health care service plans and health carriers that offer plan contracts or health benefit plans, respectively, to small employers with regard to eligible employees, as defined. Existing law prohibits a plan or solicitor or a carrier or agent or broker from encouraging or directing small employers to seek coverage from another plan or carrier or the Voluntary Alliance Uniting Employers Purchasing Program. ~~Existing law prohibits a plan or carrier from entering into any contract with a solicitor or agent or broker that provides for or results in the compensation paid to the solicitor or agent or broker to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer, except as specified.~~ Existing law also regulates provisions related to preexisting conditions and late enrollees, as defined.

For purposes of that coverage, this bill would change the definitions and criteria related to eligible employees and rating periods, and, on and after January 1, 2014, risk adjustment factors, age categories, and health status-related factors, as specified. The bill would change the definition of small employers on or after January 1, 2014, and would change the definition again on or after January 1, 2017, as specified. The bill would require employer contribution requirements to be consistent with the federal Patient Protection and Affordable Care Act. With regard to the sale of plan contracts or health benefit plans, the bill would prohibit specified persons or entities from encouraging or directing small employers to seek coverage from another plan or the voluntary purchasing pool established under the California Health Benefit Exchange. ~~On and after January 1, 2014, the bill would further prohibit a solicitor or agent or broker from entering into any contract with a plan or carrier that provides for or results in the compensation paid to the solicitor or agent or broker to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer, except as specified. On and after January 1, 2013, the bill would require every plan or carrier to file with the Department of Managed Health Care or the Department of Insurance, as applicable, every compensation agreement made with a solicitor or agent or broker.~~ The bill would make other conforming changes to implement the federal act with regard to preexisting conditions, to

become effective January 1, 2014, and would make other changes to preexisting condition provisions, notices, and provisions related to late enrollees.

Because a willful violation of the bill's provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1357 of the Health and Safety Code is
2 amended to read:
3 1357. As used in this article:
4 (a) "Dependent" means the spouse or child of an eligible
5 employee, subject to applicable terms of the health care plan
6 contract covering the employee, and includes dependents of
7 guaranteed association members if the association elects to include
8 dependents under its health coverage at the same time it determines
9 its membership composition pursuant to subdivision (o).
10 (b) "Eligible employee" means either of the following:
11 (1) Any permanent employee who is actively engaged on a
12 full-time basis in the conduct of the business of the small employer
13 with a normal workweek of an average of 30 hours per week over
14 the course of a month, at the small employer's regular places of
15 business, who has met any statutorily authorized applicable waiting
16 period requirements. The term includes sole proprietors or partners
17 of a partnership, if they are actively engaged on a full-time basis
18 in the small employer's business and included as employees under
19 a health care plan contract of a small employer, but does not
20 include employees who work on a part-time, temporary, or
21 substitute basis. It includes any eligible employee, as defined in
22 this paragraph, who obtains coverage through a guaranteed
23 association. Employees of employers purchasing through a
24 guaranteed association shall be deemed to be eligible employees

1 if they would otherwise meet the definition except for the number
2 of persons employed by the employer. Permanent employees who
3 work at least 20 hours but not more than 29 hours are deemed to
4 be eligible employees if all four of the following apply:

5 (A) They otherwise meet the definition of an eligible employee
6 except for the number of hours worked.

7 (B) The employer offers the employees health coverage under
8 a health benefit plan.

9 (C) All similarly situated individuals are offered coverage under
10 the health benefit plan.

11 (D) The employee must have worked at least 20 hours per
12 normal workweek for at least 50 percent of the weeks in the
13 previous calendar quarter. The health care service plan may request
14 any necessary information to document the hours and time period
15 in question, including, but not limited to, payroll records and
16 employee wage and tax filings.

17 (2) Any member of a guaranteed association as defined in
18 subdivision (o).

19 (c) "In force business" means an existing health benefit plan
20 contract issued by the plan to a small employer.

21 (d) "Late enrollee" means an eligible employee or dependent
22 who has declined enrollment in a health benefit plan offered by a
23 small employer at the time of the initial enrollment period provided
24 under the terms of the health benefit plan and who subsequently
25 requests enrollment in a health benefit plan of that small employer,
26 provided that the initial enrollment period shall be a period of at
27 least 30 days. It also means any member of an association that is
28 a guaranteed association as well as any other person eligible to
29 purchase through the guaranteed association when that person has
30 failed to purchase coverage during the initial enrollment period
31 provided under the terms of the guaranteed association's plan
32 contract and who subsequently requests enrollment in the plan,
33 provided that the initial enrollment period shall be a period of at
34 least 30 days. However, an eligible employee, any other person
35 eligible for coverage through a guaranteed association pursuant to
36 subdivision (o), or an eligible dependent shall not be considered
37 a late enrollee if any of the following is applicable:

38 (1) The individual meets all of the following requirements:

39 (A) He or she was covered under another employer health
40 benefit plan, the Healthy Families Program, the Access for Infants

1 and Mothers (AIM) Program, the Medi-Cal program, or the
2 California Health Benefit Exchange at the time the individual was
3 eligible to enroll.

4 (B) He or she certified at the time of the initial enrollment that
5 coverage under another employer health benefit plan, the Healthy
6 Families Program, the AIM Program, the Medi-Cal program, or
7 the California Health Benefit Exchange was the reason for
8 declining enrollment, provided that, if the individual was covered
9 under another employer health plan, the individual was given the
10 opportunity to make the certification required by this subdivision
11 and was notified that failure to do so could result in later treatment
12 as a late enrollee.

13 (C) He or she has lost or will lose coverage under another
14 employer health benefit plan as a result of termination of
15 employment of the individual or of a person through whom the
16 individual was covered as a dependent, change in employment
17 status of the individual or of a person through whom the individual
18 was covered as a dependent, termination of the other plan's
19 coverage, cessation of an employer's contribution toward an
20 employee or dependent's coverage, death of the person through
21 whom the individual was covered as a dependent, legal separation,
22 or divorce; or he or she has lost or will lose coverage under the
23 Healthy Families Program, the AIM Program, the Medi-Cal
24 program, or the California Health Benefit Exchange.

25 (D) He or she requests enrollment within 30 days after
26 termination of coverage or employer contribution toward coverage
27 provided under another employer health benefit plan, or requests
28 enrollment within 60 days after termination of Medi-Cal program
29 coverage, AIM Program coverage, Healthy Families Program
30 coverage, or coverage through the California Health Benefit
31 Exchange.

32 (2) The employer offers multiple health benefit plans and the
33 employee elects a different plan during an open enrollment period.

34 (3) A court has ordered that coverage be provided for a spouse
35 or minor child under a covered employee's health benefit plan.

36 (4) (A) ~~It~~ *Until December 31, 2013*, in the case of an eligible
37 employee, as defined in paragraph (1) of subdivision (b), the plan
38 cannot produce a written statement from the employer stating that
39 the individual or the person through whom the individual was
40 eligible to be covered as a dependent, prior to declining coverage,

1 was provided with, and signed, acknowledgment of an explicit
2 written notice in boldface type specifying that failure to elect
3 coverage during the initial enrollment period permits the plan to
4 impose, at the time of the individual's later decision to elect
5 coverage, an exclusion from coverage for a period of 12 months
6 as well as a six-month preexisting condition exclusion, unless the
7 individual meets the criteria specified in paragraph (1), (2), or (3).

8 (B) ~~In~~ *Until December 31, 2013*, in the case of an association
9 member who did not purchase coverage through a guaranteed
10 association, the plan cannot produce a written statement from the
11 association stating that the association sent a written notice in
12 boldface type to all potentially eligible association members at
13 their last known address prior to the initial enrollment period
14 informing members that failure to elect coverage during the initial
15 enrollment period permits the plan to impose, at the time of the
16 member's later decision to elect coverage, an exclusion from
17 coverage for a period of 12 months as well as a six-month
18 preexisting condition exclusion unless the member can demonstrate
19 that he or she meets the requirements of subparagraphs (A), (C),
20 and (D) of paragraph (1) or meets the requirements of paragraph
21 (2) or (3).

22 (C) In the case of an employer or person who is not a member
23 of an association, was eligible to purchase coverage through a
24 guaranteed association, and did not do so, and would not be eligible
25 to purchase guaranteed coverage unless purchased through a
26 guaranteed association, the employer or person can demonstrate
27 that he or she meets the requirements of subparagraphs (A), (C),
28 and (D) of paragraph (1), or meets the requirements of paragraph
29 (2) or (3), or that he or she recently had a change in status that
30 would make him or her eligible and that application for enrollment
31 was made within 30 days of the change.

32 (5) The individual is an employee or dependent who meets the
33 criteria described in paragraph (1) and was under a COBRA
34 continuation provision and the coverage under that provision has
35 been exhausted. For purposes of this section, the definition of
36 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
37 apply.

38 (6) The individual is a dependent of an enrolled eligible
39 employee who has lost or will lose his or her coverage under the
40 Healthy Families Program, the AIM Program, the Medi-Cal

1 program, or the California Health Benefit Exchange, and requests
2 enrollment within 60 days after termination of that coverage.

3 (7) The individual is an eligible employee who previously
4 declined coverage under an employer health benefit plan and who
5 has subsequently acquired a dependent who would be eligible for
6 coverage as a dependent of the employee through marriage, birth,
7 adoption, or placement for adoption, and who enrolls for coverage
8 under that employer health benefit plan on his or her behalf and
9 on behalf of his or her dependent within 30 days following the
10 date of marriage, birth, adoption, or placement for adoption, in
11 which case the effective date of coverage shall be the first day of
12 the month following the date the completed request for enrollment
13 is received in the case of marriage, or the date of birth, or the date
14 of adoption or placement for adoption, whichever applies. Notice
15 of the special enrollment rights contained in this paragraph shall
16 be provided by the employer to an employee at or before the time
17 the employee is offered an opportunity to enroll in plan coverage.

18 (8) The individual is an eligible employee who has declined
19 coverage for himself or herself or his or her dependents during a
20 previous enrollment period because his or her dependents were
21 covered by another employer health benefit plan at the time of the
22 previous enrollment period. That individual may enroll himself or
23 herself or his or her dependents for plan coverage during a special
24 open enrollment opportunity if his or her dependents have lost or
25 will lose coverage under that other employer health benefit plan.
26 The special open enrollment opportunity shall be requested by the
27 employee not more than 30 days after the date that the other health
28 coverage is exhausted or terminated. Upon enrollment, coverage
29 shall be effective not later than the first day of the first calendar
30 month beginning after the date the request for enrollment is
31 received. Notice of the special enrollment rights contained in this
32 paragraph shall be provided by the employer to an employee at or
33 before the time the employee is offered an opportunity to enroll
34 in plan coverage.

35 (e) “New business” means a health care service plan contract
36 issued to a small employer that is not the plan’s in force business.

37 (f) (1) ~~Until January 1, 2014~~ *December 31, 2013*, “preexisting
38 condition provision” means a contract provision that excludes
39 coverage for charges or expenses incurred during a specified period
40 following the employee’s effective date of coverage, as to a

1 condition for which medical advice, diagnosis, care, or treatment
2 was recommended or received during a specified period
3 immediately preceding the effective date of coverage.

4 (2) On and after January 1, 2014, no health care service plan
5 shall limit or exclude coverage for any individual based on a
6 preexisting condition whether or not any medical advice, diagnosis,
7 care, or treatment was recommended or received before that date.

8 (g) “Creditable coverage” means:

9 (1) Any individual or group policy, contract, or program that is
10 written or administered by a disability insurer, health care service
11 plan, fraternal benefits society, self-insured employer plan, or any
12 other entity, in this state or elsewhere, and that arranges or provides
13 medical, hospital, and surgical coverage not designed to supplement
14 other private or governmental plans. The term includes continuation
15 or conversion coverage but does not include accident only, credit,
16 coverage for onsite medical clinics, disability income, Medicare
17 supplement, long-term care, dental, vision, coverage issued as a
18 supplement to liability insurance, insurance arising out of a
19 workers’ compensation or similar law, automobile medical payment
20 insurance, or insurance under which benefits are payable with or
21 without regard to fault and that is statutorily required to be
22 contained in any liability insurance policy or equivalent
23 self-insurance.

24 (2) The Medicare Program pursuant to Title XVIII of the federal
25 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

26 (3) The Medicaid Program pursuant to Title XIX of the federal
27 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

28 (4) Any other publicly sponsored program, provided in this state
29 or elsewhere, of medical, hospital, and surgical care.

30 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
31 (Civilian Health and Medical Program of the Uniformed Services
32 (CHAMPUS)).

33 (6) A medical care program of the Indian Health Service or of
34 a tribal organization.

35 (7) A state health benefits risk pool.

36 (8) A health plan offered under 5 U.S.C. Chapter 89
37 (commencing with Section 8901) (Federal Employees Health
38 Benefits Program (FEHBP)).

39 (9) A public health plan as defined in federal regulations
40 authorized by Section 2701(c)(1)(I) of the Public Health Service

Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e)~~ 300gg-3(c)).

(h) “Rating period” means the period for which premium rates established by a plan are in effect and shall be no less than 12 months.

(i) “Risk adjusted employee risk rate” means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(j) “Risk adjustment factor” means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, ~~the risk adjustment factor shall be zero~~ *no risk adjustment factor shall be used in the determination of rates.*

(k) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer *to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided

1 by the Medicare Program pursuant to Title XVIII of the federal
2 Social Security Act (42 U.S.C. Sec. 1395 et seq.). Effective January
3 1, 2014, the rate for age shall not vary by more than three to one
4 for adults.

5 (2) Small employer health care service plans shall base rates to
6 small employers using no more than the following family size
7 categories:

8 (A) Single.

9 (B) Married couple.

10 (C) One adult and child or children.

11 (D) Married couple and child or children.

12 (3) (A) In determining rates for small employers, a plan that
13 operates statewide shall use no more than nine geographic regions
14 in the state, have no region smaller than an area in which the first
15 three digits of all its ZIP Codes are in common within a county,
16 and divide no county into more than two regions. Plans shall be
17 deemed to be operating statewide if their coverage area includes
18 90 percent or more of the state's population. Geographic regions
19 established pursuant to this section shall, as a group, cover the
20 entire state, and the area encompassed in a geographic region shall
21 be separate and distinct from areas encompassed in other
22 geographic regions. Geographic regions may be noncontiguous.

23 (B) (i) In determining rates for small employers, a plan that
24 does not operate statewide shall use no more than the number of
25 geographic regions in the state that is determined by the following
26 formula: the population, as determined in the last federal census,
27 of all counties that are included in their entirety in a plan's service
28 area divided by the total population of the state, as determined in
29 the last federal census, multiplied by nine. The resulting number
30 shall be rounded to the nearest whole integer. No region may be
31 smaller than an area in which the first three digits of all its ZIP
32 Codes are in common within a county and no county may be
33 divided into more than two regions. The area encompassed in a
34 geographic region shall be separate and distinct from areas
35 encompassed in other geographic regions. Geographic regions
36 may be noncontiguous. No plan shall have less than one geographic
37 area.

38 (ii) If the formula in clause (i) results in a plan that operates in
39 more than one county having only one geographic region, then the
40 formula in clause (i) shall not apply and the plan may have two

1 geographic regions, provided that no county is divided into more
2 than one region.

3 Nothing in this section shall be construed to require a plan to
4 establish a new service area or to offer health coverage on a
5 statewide basis, outside of the plan's existing service area.

6 (l) "Small employer" means any of the following:

7 (1) ~~Until January 1, 2014~~ *December 31, 2013*, any person, firm,
8 proprietary or nonprofit corporation, partnership, public agency,
9 or association that is actively engaged in business or service, that,
10 on at least 50 percent of its working days during the preceding
11 calendar quarter or preceding calendar year, employed at least two,
12 but no more than 50, eligible employees, the majority of whom
13 were employed within this state, that was not formed primarily for
14 purposes of buying health care service plan contracts, and in which
15 a bona fide employer-employee relationship exists. On or after
16 January 1, 2014, and until December 31, ~~2016~~ *2015*, any person,
17 firm, proprietary or nonprofit corporation, partnership, public
18 agency, or association that is actively engaged in business or
19 service, that, on at least 50 percent of its working days during the
20 preceding calendar quarter or preceding calendar year, employed
21 at least one, but no more than 50, eligible employees, the majority
22 of whom were employed within this state, that was not formed
23 primarily for purposes of buying health care service plan contracts,
24 and in which a bona fide employer-employee relationship exists.
25 On or after January 1, ~~2017~~ *2016*, any person, firm, proprietary or
26 nonprofit corporation, partnership, public agency, or association
27 that is actively engaged in business or service, that, on at least 50
28 percent of its working days during the preceding calendar quarter
29 or preceding calendar year, employed at least one, but no more
30 than 100, eligible employees, the majority of whom were employed
31 within this state, that was not formed primarily for purposes of
32 buying health care service plan contracts, and in which a bona fide
33 employer-employee relationship exists. In determining whether
34 to apply the calendar quarter or calendar year test, a health care
35 service plan shall use the test that ensures eligibility if only one
36 test would establish eligibility. In determining the number of
37 eligible employees, companies that are affiliated companies and
38 that are eligible to file a combined tax return for purposes of state
39 taxation shall be considered one employer. Subsequent to the
40 issuance of a health care service plan contract to a small employer

1 pursuant to this article, and for the purpose of determining
2 eligibility, the size of a small employer shall be determined
3 annually. Except as otherwise specifically provided in this article,
4 provisions of this article that apply to a small employer shall
5 continue to apply until the plan contract anniversary following the
6 date the employer no longer meets the requirements of this
7 definition. It includes any small employer as defined in this
8 paragraph who purchases coverage through a guaranteed
9 association, and any employer purchasing coverage for employees
10 through a guaranteed association. *This paragraph shall be*
11 *implemented to the extent consistent with the federal Patient*
12 *Protection and Affordable Care Act (Public Law 111-148) and*
13 *any rules, regulations, or guidance issued consistent with that law.*

14 (2) Any guaranteed association, as defined in subdivision (n),
15 that purchases health coverage for members of the association.

16 (3) On or after January 1, 2014, a self-employed individual who
17 obtains at least 50 percent of annual income from self-employment
18 as demonstrated through personal income tax filings for the current
19 or prior year. To the extent permitted under the federal Patient
20 Protection and Affordable Care Act (Public Law 111-148) and
21 any rules, regulations, or guidance issued consistent with that law,
22 a self-employed individual whose modified annual gross income
23 is anticipated to be less than 400 percent of the federal poverty
24 level may at his or her discretion seek to enroll as an individual
25 rather than a small employer through the California Health Benefit
26 Exchange *to the extent permitted under the federal Patient*
27 *Protection and Affordable Care Act (Public Law 111-148) and*
28 *any rules, regulations, or guidance issued consistent with that law.*

29 (m) “Standard employee risk rate” means the rate applicable to
30 an eligible employee in a particular risk category in a small
31 employer group.

32 (n) “Guaranteed association” means a nonprofit organization
33 comprised of a group of individuals or employers who associate
34 based solely on participation in a specified profession or industry,
35 accepting for membership any individual or employer meeting its
36 membership criteria, and that (1) includes one or more small
37 employers as defined in paragraph (1) of subdivision (l), (2) does
38 not condition membership directly or indirectly on the health or
39 claims history of any person, (3) uses membership dues solely for
40 and in consideration of the membership and membership benefits,

1 except that the amount of the dues shall not depend on whether
2 the member applies for or purchases insurance offered to the
3 association, (4) is organized and maintained in good faith for
4 purposes unrelated to insurance, (5) has been in active existence
5 on January 1, 1992, and for at least five years prior to that date,
6 (6) has included health insurance as a membership benefit for at
7 least five years prior to January 1, 1992, (7) has a constitution and
8 bylaws, or other analogous governing documents that provide for
9 election of the governing board of the association by its members,
10 (8) offers any plan contract that is purchased to all individual
11 members and employer members in this state, (9) includes any
12 member choosing to enroll in the plan contracts offered to the
13 association provided that the member has agreed to make the
14 required premium payments, and (10) covers at least 1,000 persons
15 with the health care service plan with which it contracts. The
16 requirement of 1,000 persons may be met if component chapters
17 of a statewide association contracting separately with the same
18 carrier cover at least 1,000 persons in the aggregate.

19 This subdivision applies regardless of whether a contract issued
20 by a plan is with an association, or a trust formed for or sponsored
21 by an association, to administer benefits for association members.

22 For purposes of this subdivision, an association formed by a
23 merger of two or more associations after January 1, 1992, and
24 otherwise meeting the criteria of this subdivision shall be deemed
25 to have been in active existence on January 1, 1992, if its
26 predecessor organizations had been in active existence on January
27 1, 1992, and for at least five years prior to that date and otherwise
28 met the criteria of this subdivision.

29 (o) "Members of a guaranteed association" means any individual
30 or employer meeting the association's membership criteria if that
31 person is a member of the association and chooses to purchase
32 health coverage through the association. At the association's
33 discretion, it also may include employees of association members,
34 association staff, retired members, retired employees of members,
35 and surviving spouses and dependents of deceased members.
36 However, if an association chooses to include these persons as
37 members of the guaranteed association, the association shall make
38 that election in advance of purchasing a plan contract. Health care
39 service plans may require an association to adhere to the
40 membership composition it selects for up to 12 months.

1 (p) “Affiliation period” means a period that, under the terms of
2 the health care service plan contract, must expire before health
3 care services under the contract become effective.

4 SEC. 2. Section 1357.03 of the Health and Safety Code is
5 amended to read:

6 1357.03. (a) (1) Upon the effective date of this article, a plan
7 shall fairly and affirmatively offer, market, and sell all of the plan’s
8 health care service plan contracts that are sold to small employers
9 or to associations that include small employers to all small
10 employers in each service area in which the plan provides or
11 arranges for the provision of health care services.

12 (2) Each plan shall make available to each small employer all
13 small employer health care service plan contracts that the plan
14 offers and sells to small employers or to associations that include
15 small employers in this state.

16 (3) No plan or solicitor shall induce or otherwise encourage a
17 small employer to separate or otherwise exclude an eligible
18 employee from a health care service plan contract that is provided
19 in connection with the employee’s employment or membership in
20 a guaranteed association.

21 (4) A plan contracting to participate in the voluntary purchasing
22 pool for small employers offered through the California Health
23 Benefit Exchange shall be deemed in compliance with the
24 requirements of paragraph (1) for a contract offered through the
25 California Health Benefit Exchange in those geographic regions
26 in which plans participate in the California Health Benefit
27 Exchange.

28 (5) (A) A plan shall be deemed to meet the requirements of
29 paragraphs (1) and (2) with respect to a plan contract that qualifies
30 as a grandfathered health plan under Section 1251 of PPACA if
31 all of the following requirements are met:

32 (i) The plan offers to renew the plan contract, unless the plan
33 withdraws the plan contract from the small employer market
34 pursuant to subdivision (e) of Section 1357.11.

35 (ii) The plan provides appropriate notice of the grandfathered
36 status of the contract in any materials provided to an enrollee of
37 the contract describing the benefits provided under the contract,
38 as required under PPACA.

39 (iii) The plan makes no changes to the benefits covered under
40 the plan contract other than those required by a state or federal

1 law, regulation, rule, or guidance and those permitted to be made
2 to a grandfathered health plan under PPACA.

3 (B) For purposes of this paragraph, “PPACA” means the federal
4 Patient Protection and Affordable Care Act (Public Law 111-148),
5 as amended by the federal Health Care and Education
6 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
7 regulations, or guidance issued thereunder. For purposes of this
8 paragraph, a “grandfathered health plan” shall have the meaning
9 set forth in Section 1251 of PPACA.

10 (b) Every plan shall file with the director the reasonable
11 employee participation requirements and employer contribution
12 requirements that will be applied in offering its plan contracts.
13 Participation requirements shall be applied uniformly among all
14 small employer groups, except that a plan may vary application
15 of minimum employee participation requirements by the size of
16 the small employer group and whether the employer contributes
17 100 percent of the eligible employee’s premium. Employer
18 contribution requirements shall not vary by employer size.
19 Employer contribution requirements shall be consistent with the
20 federal Patient Protection and Affordable Care Act (Public Law
21 111-148). A health care service plan shall not establish a
22 participation requirement that (1) requires a person who meets the
23 definition of a dependent in subdivision (a) of Section 1357 to
24 enroll as a dependent if he or she is otherwise eligible for coverage
25 and wishes to enroll as an eligible employee and (2) allows a plan
26 to reject an otherwise eligible small employer because of the
27 number of persons that waive coverage due to coverage through
28 another employer. Members of an association eligible for health
29 coverage under subdivision (o) of Section 1357, but not electing
30 any health coverage through the association, shall not be counted
31 as eligible employees for purposes of determining whether the
32 guaranteed association meets a plan’s reasonable participation
33 standards.

34 (c) The plan shall not reject an application from a small
35 employer for a health care service plan contract if all of the
36 following are met:

37 (1) The small employer, as defined by paragraph (1) of
38 subdivision (l) of Section 1357, offers health benefits to 100
39 percent of its eligible employees, as defined by paragraph (1) of
40 subdivision (b) of Section 1357. Employees who waive coverage

1 on the grounds that they have other group coverage shall not be
2 counted as eligible employees.

3 (2) The small employer agrees to make the required premium
4 payments.

5 (3) The small employer agrees to inform the small employers'
6 employees of the availability of coverage and the provision that
7 those not electing coverage must wait one year to obtain coverage
8 through the group if they later decide they would like to have
9 coverage.

10 (4) The employees and their dependents who are to be covered
11 by the plan contract work or reside in the service area in which
12 the plan provides or otherwise arranges for the provision of health
13 care services.

14 (d) No plan or solicitor shall, directly or indirectly, engage in
15 the following activities:

16 (1) Encourage or direct small employers to refrain from filing
17 an application for coverage with a plan because of the health status,
18 claims experience, industry, occupation of the small employer, or
19 geographic location provided that it is within the plan's approved
20 service area.

21 (2) Encourage or direct small employers to seek coverage from
22 another plan or the voluntary purchasing pool established under
23 the California Health Benefit Exchange because of the health
24 status, claims experience, industry, occupation of the small
25 employer, or geographic location provided that it is within the
26 plan's approved service area.

27 (e) ~~(f)~~—A plan shall not, directly or indirectly, enter into any
28 contract, agreement, or arrangement with a solicitor that provides
29 for or results in the compensation paid to a solicitor for the sale of
30 a health care service plan contract to be varied because of the health
31 status, claims experience, industry, occupation, or geographic
32 location of the small employer *or small employer's employees*.
33 This ~~paragraph~~ *subdivision* does not apply to a compensation
34 arrangement that provides compensation to a solicitor on the basis
35 of percentage of premium, provided that the percentage shall not
36 vary because of the health status, claims experience, industry,
37 occupation, or geographic area of the small employer.

38 ~~(2) On and after January 1, 2014, a solicitor shall not, directly~~
39 ~~or indirectly, enter into any contract, agreement, or arrangement~~
40 ~~with a plan that provides for or results in the compensation paid~~

1 to a solicitor for the sale of a health care service plan contract to
2 be varied because of the health status, claims experience, industry,
3 occupation, or geographic location of the small employer. This
4 paragraph does not apply to a compensation arrangement that
5 provides compensation to a solicitor on the basis of percentage of
6 premium, provided that the percentage shall not vary because of
7 the health status, claims experience, industry, occupation, or
8 geographic area of the small employer.

9 ~~(3) On and after January 1, 2013, a plan shall file with the~~
10 ~~department any and all compensation agreements with solicitors~~
11 ~~so that the department may monitor for compliance with this~~
12 ~~section.~~

13 (f) A policy or contract that covers one or more employees shall
14 not establish rules for eligibility, including continued eligibility,
15 of an individual, or dependent of an individual, to enroll under the
16 terms of the plan based on any of the following health status-related
17 factors:

- 18 (1) Health status.
- 19 (2) Medical condition, including physical and mental illnesses.
- 20 (3) Claims experience.
- 21 (4) Receipt of health care.
- 22 (5) Medical history.
- 23 (6) Genetic information.
- 24 (7) Evidence of insurability, including conditions arising out of
25 acts of domestic violence.
- 26 (8) Disability.
- 27 (9) Any other health status-related factor as determined by the
28 department.

29 (g) A plan shall comply with the requirements of Section 1374.3.
30 SEC. 3. Section 1357.05 of the Health and Safety Code is
31 amended to read:

32 1357.05. (a) ~~Until January 1, 2014~~ *December 31, 2013*, except
33 in the case of a late enrollee, or for satisfaction of a preexisting
34 condition clause in the case of initial coverage of an eligible
35 employee, a plan may not exclude any eligible employee or
36 dependent who would otherwise be entitled to health care services
37 on the basis of an actual or expected health condition of that
38 employee or dependent. No plan contract may limit or exclude
39 coverage for a specific eligible employee or dependent by type of

1 illness, treatment, medical condition, or accident, except for
2 preexisting conditions as permitted by Section 1357.06.

3 (b) On or after January 1, 2014, a plan may not exclude any
4 eligible employee or dependent who would otherwise be entitled
5 to health care services on the basis of an actual or expected health
6 condition of that employee or dependent. No plan contract may
7 limit or exclude coverage for a specific eligible employee or
8 dependent by type of illness, treatment, medical condition, or
9 accident, except for preexisting conditions as permitted by Section
10 1357.06.

11 SEC. 4. Section 1357.06 of the Health and Safety Code is
12 amended to read:

13 1357.06. (a) (1) ~~Until January 1, 2014~~ *December 31, 2013*,
14 preexisting condition provisions of a plan contract shall not exclude
15 coverage for a period beyond six months following the individual's
16 effective date of coverage and may only relate to conditions for
17 which medical advice, diagnosis, care, or treatment, including
18 prescription drugs, was recommended or received from a licensed
19 health practitioner during the six months immediately preceding
20 the effective date of coverage.

21 (2) Notwithstanding paragraph (1), a plan contract offered to a
22 small employer shall not impose any preexisting condition
23 provision upon any child under 19 years of age.

24 (3) On or after January 1, 2014, preexisting condition provisions
25 of a plan contract shall not exclude coverage following the
26 individual's effective date of coverage for a condition based on
27 the fact that the condition was present before the date of enrollment
28 of the coverage, whether or not any medical advice, diagnosis,
29 care, or treatment was recommended or received before that date.

30 (b) (1) ~~Until January 1, 2014~~ *December 31, 2013*, a plan that
31 does not utilize a preexisting condition provision may impose a
32 waiting or affiliation period, not to exceed 60 days, before the
33 coverage issued subject to this article shall become effective.
34 During the waiting or affiliation period no premiums shall be
35 charged to the enrollee or the subscriber.

36 (2) On or after January 1, 2014, no waiting or affiliation period
37 based on a preexisting condition, health status, or any other factor
38 prohibited under subdivision (f) of Section 1357.03 shall be
39 imposed.

1 (3) *A plan contract may permit a waiting period of up to 90*
2 *days as a condition of enrollment if applied equally to all full-time*
3 *employees and if consistent with the federal Patient Protection*
4 *and Affordable Care Act (Public Law 111-148) and any rules,*
5 *regulations, or guidance issued consistent with that law.*

6 (c) ~~Until January 1, 2014~~ *December 31, 2013*, in determining
7 whether a preexisting condition provision or a waiting or affiliation
8 period applies to any person, a plan shall credit the time the person
9 was covered under creditable coverage, provided the person
10 becomes eligible for coverage under the succeeding plan contract
11 within 62 days of termination of prior coverage, exclusive of any
12 waiting or affiliation period, and applies for coverage with the
13 succeeding plan contract within the applicable enrollment period.
14 A plan shall also credit any time an eligible employee must wait
15 before enrolling in the plan, including any affiliation or
16 employer-imposed waiting or affiliation period. However, if a
17 person's employment has ended, the availability of health coverage
18 offered through employment or sponsored by an employer has
19 terminated, or an employer's contribution toward health coverage
20 has terminated, a plan shall credit the time the person was covered
21 under creditable coverage if the person becomes eligible for health
22 coverage offered through employment or sponsored by an employer
23 within 180 days, exclusive of any waiting or affiliation period, and
24 applies for coverage under the succeeding plan contract within the
25 applicable enrollment period.

26 (d) ~~Until January 1, 2014~~ *December 31, 2013*, in addition to the
27 preexisting condition exclusions authorized by subdivision (a) and
28 the waiting or affiliation period authorized by subdivision (b),
29 health plans providing coverage to a guaranteed association may
30 impose on employers or individuals purchasing coverage who
31 would not be eligible for guaranteed coverage if they were not
32 purchasing through the association a waiting or affiliation period,
33 not to exceed 60 days, before the coverage issued subject to this
34 article shall become effective. During the waiting or affiliation
35 period, no premiums shall be charged to the enrollee or the
36 subscriber.

37 (e) An individual's period of creditable coverage shall be
38 certified pursuant to subdivision (e) of Section 2701 of Title XXVII
39 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e)~~)
40 *300gg-3(e)*).

1 (f) A health care service plan issuing group coverage may not
2 impose a preexisting condition exclusion to a condition relating
3 to benefits for pregnancy or maternity care.

4 SEC. 5. Section 1357.07 of the Health and Safety Code is
5 amended to read:

6 1357.07. (a) ~~Until January 1, 2014~~ *December 31, 2013*, no
7 plan contract may exclude late enrollees from coverage for more
8 than 12 months from the date of the late enrollees application for
9 coverage. No premium shall be charged to the late enrollee until
10 the exclusion period has ended.

11 (b) On or after January 1, 2014, no plan contract may exclude
12 a late enrollee from coverage for more than 90 days from the date
13 of the late enrollee's application for coverage *to the extent*
14 *consistent with the federal Patient Protection and Affordable Care*
15 *Act (Public Law 111-148) and any rules, regulations, or guidance*
16 *issued consistent with that law*. No premium shall be charged to
17 the late enrollee until the exclusion period has ended.

18 SEC. 6. Section 1357.12 of the Health and Safety Code is
19 amended to read:

20 1357.12. Premiums for contracts offered or delivered by plans
21 on or after the effective date of this article shall be subject to the
22 following requirements:

23 (a) (1) The premium for new business shall be determined for
24 an eligible employee in a particular risk category after applying a
25 risk adjustment factor to the plan's standard employee risk rates.
26 The risk adjusted employee risk rate may not be more than 120
27 percent or less than 80 percent of the plan's applicable standard
28 employee risk rate until July 1, 1996. Effective July 1, 1996, this
29 factor may not be more than 110 percent or less than 90 percent.
30 Effective January 1, 2014, ~~the risk adjustment factor shall be zero~~
31 *no risk adjustment factor shall be used in the determination of*
32 *rates*.

33 (2) The premium charged a small employer for new business
34 shall be equal to the sum of the risk adjusted employee risk rates.

35 (3) The standard employee risk rates applied to a small employer
36 for new business shall be in effect for no less than 12 months.

37 (b) (1) The premium for in force business shall be determined
38 for an eligible employee in a particular risk category after applying
39 a risk adjustment factor to the plan's standard employee risk rates.
40 The risk adjusted employee risk rates may not be more than 120

1 percent or less than 80 percent of the plan's applicable standard
 2 employee risk rate until July 1, 1996. Effective July 1, 1996, this
 3 factor may not be more than 110 percent or less than 90 percent.
 4 The factor effective July 1, 1996, shall apply to in force business
 5 at the earlier of either the time of renewal or July 1, 1997. Until
 6 ~~January 1, 2014~~ *December 31, 2013*, the risk adjustment factor
 7 applied to a small employer may not increase by more than 10
 8 percentage points from the risk adjustment factor applied in the
 9 prior rating period. Effective January 1, 2014, ~~the risk adjustment~~
 10 ~~factor shall be zero~~ *no risk adjustment factor shall be used in the*
 11 *determination of rates*. The risk adjustment factor for a small
 12 employer may not be modified more frequently than every 12
 13 months.

14 (2) The premium charged a small employer for in force business
 15 shall be equal to the sum of the risk adjusted employee risk rates.
 16 The standard employee risk rates shall be in effect for no less than
 17 six months.

18 (3) For a contract that a plan has discontinued offering, the risk
 19 adjustment factor applied to the standard employee risk rates for
 20 the first rating period of the new contract that the small employer
 21 elects to purchase shall be no greater than the risk adjustment factor
 22 applied in the prior rating period to the discontinued contract.
 23 However, the risk adjusted employee risk rate may not be more
 24 than 120 percent or less than 80 percent of the plan's applicable
 25 standard employee risk rate until July 1, 1996. Effective July 1,
 26 1996, this factor may not be more than 110 percent or less than 90
 27 percent. The factor effective July 1, 1996, shall apply to in force
 28 business at the earlier of either the time of renewal or July 1, 1997.
 29 Effective January 1, 2014, ~~the risk adjustment factor shall be zero~~
 30 *no risk adjustment factor shall be used in the determination of*
 31 *rates*. The risk adjustment factor for a small employer may not be
 32 modified more frequently than every 12 months.

33 (c) (1) For any small employer, a plan may, with the consent
 34 of the small employer, establish composite employee and
 35 dependent rates for either new business or renewal of in force
 36 business. The composite rates shall be determined as the average
 37 of the risk adjusted employee risk rates for the small employer, as
 38 determined in accordance with the requirements of subdivisions
 39 (a) and (b). The sum of the composite rates so determined shall be

1 equal to the sum of the risk adjusted employee risk rates for the
2 small employer.

3 (2) The composite rates shall be used for all employees and
4 dependents covered throughout a rating period of no less than six
5 months nor more than 12 months, except that a plan may reserve
6 the right to redetermine the composite rates if the enrollment under
7 the contract changes by more than a specified percentage during
8 the rating period. Any redetermination of the composite rates shall
9 be based on the same risk adjusted employee risk rates used to
10 determine the initial composite rates for the rating period. If a plan
11 reserves the right to redetermine the rates and the enrollment
12 changes more than the specified percentage, the plan shall
13 redetermine the composite rates if the redetermined rates would
14 result in a lower premium for the small employer. A plan reserving
15 the right to redetermine the composite rates based upon a change
16 in enrollment shall use the same specified percentage to measure
17 that change with respect to all small employers electing composite
18 rates.

19 SEC. 7. Section 1357.14 of the Health and Safety Code is
20 amended to read:

21 1357.14. In connection with the offering for sale of any plan
22 contract to a small employer, each plan shall make a reasonable
23 disclosure, as part of its solicitation and sales materials, of the
24 following:

25 (a) ~~Until January 1, 2014~~ *December 31, 2013*, the extent to
26 which premium rates for a specified small employer are established
27 or adjusted in part based upon the actual or expected variation in
28 service costs or actual or expected variation in health condition of
29 the employees and dependents of the small employer.

30 (b) The provisions concerning the plan's right to change
31 premium rates and the factors other than provision of services
32 experience that affect changes in premium rates.

33 (c) Provisions relating to the guaranteed issue and renewal of
34 contracts.

35 (d) ~~Until January 1, 2014~~ *December 31, 2013*, provisions
36 relating to the effect of any preexisting condition provision.

37 (e) Provisions relating to the small employer's right to apply
38 for any contract written, issued, or administered by the plan at the
39 time of application for a new health care service plan contract, or
40 at the time of renewal of a health care service plan contract.

1 (f) The availability, upon request, of a listing of all the plan's
2 contracts and benefit plan designs offered to small employers,
3 including the rates for each contract.

4 (g) At the time it offers a contract to a small employer, each
5 plan shall provide the small employer with a statement of all of
6 its plan contracts offered to small employers, including the rates
7 for each plan contract, in the service area in which the employer's
8 employees and eligible dependents who are to be covered by the
9 plan contract work or reside. For purposes of this subdivision,
10 plans that are affiliated plans or that are eligible to file a
11 consolidated income tax return shall be treated as one health plan.

12 (h) Each plan shall do all of the following:

13 (1) Prepare a brochure that summarizes all of its plan contracts
14 offered to small employers and to make this summary available
15 to any small employer and to solicitors upon request. The summary
16 shall include for each contract information on benefits provided,
17 a generic description of the manner in which services are provided,
18 such as how access to providers is limited, benefit limitations,
19 required copayments and deductibles, standard employee risk rates,
20 and, ~~until January 1, 2014~~ *December 31, 2013*, an explanation of
21 the manner in which creditable coverage is calculated if a
22 preexisting condition or affiliation period is imposed. The summary
23 shall also include a phone number that can be called for more
24 detailed benefit information. Plans are required to keep the
25 information contained in the brochure accurate and up to date and,
26 upon updating the brochure, send copies to solicitors and solicitor
27 firms with whom the plan contracts to solicit enrollments or
28 subscriptions.

29 (2) For each contract, prepare a more detailed evidence of
30 coverage and make it available to small employers, solicitors, and
31 solicitor firms upon request. The evidence of coverage shall contain
32 all information that a prudent buyer would need to be aware of in
33 making contract selections.

34 (3) Provide to small employers and solicitors, upon request, for
35 any given small employer the sum of the standard employee risk
36 rates and the sum of the risk adjusted employee risk rates. When
37 requesting this information, small employers, solicitors, and
38 solicitor firms shall provide the plan with the information the plan
39 needs to determine the small employer's risk adjusted employee
40 risk rate.

1 (4) Provide copies of the current summary brochure to all
2 solicitors and solicitor firms contracting with the plan to solicit
3 enrollments or subscriptions from small employers.

4 For purposes of this subdivision, plans that are affiliated plans
5 or that are eligible to file a consolidated income tax return shall
6 be treated as one health plan.

7 (i) Every solicitor or solicitor firm contracting with one or more
8 plans to solicit enrollments or subscriptions from small employers
9 shall do all of the following:

10 (1) When providing information on contracts to a small
11 employer but making no specific recommendations on particular
12 plan contracts:

13 (A) Advise the small employer of the plan's obligation to sell
14 to any small employer any plan contract it offers to small
15 employers and provide them, upon request, with the actual rates
16 that would be charged to that employer for a given contract.

17 (B) Notify the small employer that the solicitor or solicitor firm
18 will procure rate and benefit information for the small employer
19 on any plan contract offered by a plan whose contract the solicitor
20 sells.

21 (C) Notify the small employer that upon request the solicitor or
22 solicitor firm will provide the small employer with the summary
23 brochure required under paragraph (1) of subdivision (h) for any
24 plan contract offered by a plan with whom the solicitor or solicitor
25 firm has contracted with to solicit enrollments or subscriptions.

26 (D) Notify the small employer of the availability of coverage
27 through the California Health Benefit Exchange *and the availability*
28 *of tax credits for certain employers, and effective January 1, 2014,*
29 *the availability of tax credits through the Exchange.*

30 (2) When recommending a particular benefit plan design or
31 designs, advise the small employer that, upon request, the agent
32 will provide the small employer with the brochure required by
33 paragraph (1) of subdivision (h) containing the benefit plan design
34 or designs being recommended by the agent or broker.

35 (3) Prior to filing an application for a small employer for a
36 particular contract:

37 (A) For each of the plan contracts offered by the plan whose
38 contract the solicitor or solicitor firm is offering, provide the small
39 employer with the benefit summary required in paragraph (1) of

1 subdivision (h) and the sum of the standard employee risk rates
2 for that particular employer.

3 (B) Notify the small employer that, upon request, the solicitor
4 or solicitor firm will provide the small employer with an evidence
5 of coverage brochure for each contract the plan offers.

6 (C) ~~Until January 1, 2014~~ *December 31, 2013*, notify the small
7 employer that actual rates may be 10 percent higher or lower than
8 the sum of the standard employee risk rates, depending on how
9 the plan assesses the risk of the small employer's group.

10 (D) ~~Until January 1, 2014~~ *December 31, 2013*, notify the small
11 employer that, upon request, the solicitor or solicitor firm will
12 submit information to the plan to ascertain the small employer's
13 sum of the risk adjusted employee risk rate for any contract the
14 plan offers. On or after July 1, 2013, notify the small employer of
15 the employee rate effective January 1, 2014.

16 (E) Obtain a signed statement from the small employer
17 acknowledging that the small employer has received the disclosures
18 required by this section.

19 SEC. 8. Section 1357.15 of the Health and Safety Code is
20 amended to read:

21 1357.15. (a) At least 60 calendar days prior to renewing or
22 amending a plan contract subject to this article which will be in
23 force on the operative date of this article, a plan shall file a notice
24 of material modification with the director in accordance with the
25 provisions of Section 1352. The notice of material modification
26 shall include a statement certifying that the plan is in compliance
27 with subdivision (j) of Section 1357 and Section 1357.12. For rates
28 in effect until January 1, 2014, the certified statement shall set
29 forth the standard employee risk rate for each risk category and
30 the highest and lowest risk adjustment factors that will be used in
31 setting the rates at which the contract will be renewed or amended.
32 Any action by the director, as permitted under Section 1352, to
33 disapprove, suspend, or postpone the plan's use of a plan contract
34 shall be in writing, specifying the reasons that the plan contract
35 does not comply with the requirements of this chapter.

36 (b) At least 60 calendar days prior to offering a plan contract
37 subject to this article, all plans shall file a notice of material
38 modification with the director in accordance with the provisions
39 of Section 1352. The notice of material modification shall include
40 a statement certifying that the plan is in compliance with

subdivision (j) of Section 1357 and Section 1357.12. For rates in effect until January 1, 2014, the certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to a small employer plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(c) Prior to making any changes in the risk categories or standard employee risk rates filed with the director pursuant to subdivision (a) or (b), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard employee risk rate is being changed, and not the risk categories, a plan may commence offering plan contracts utilizing the changed standard employee risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

(d) Periodic changes to the standard employee risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).

(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.

(f) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular small employer.

(g) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.

1 (h) This section shall remain in effect only until January 1, 2014,
2 and as of that date is repealed, unless a later enacted statute, that
3 is enacted before January 1, 2014, deletes or extends that date.

4 SEC. 9. Section 1357.15 is added to the Health and Safety
5 Code, to read:

6 1357.15. (a) At least 60 calendar days prior to renewing or
7 amending a plan contract subject to this article which will be in
8 force on the operative date of this article, a plan shall file a notice
9 of material modification with the director in accordance with the
10 provisions of Section 1352. The notice of material modification
11 shall include a statement certifying that the plan is in compliance
12 with subdivision (j) of Section 1357 and Section 1357.12. Any
13 action by the director, as permitted under Section 1352, to
14 disapprove, suspend, or postpone the plan's use of a plan contract
15 shall be in writing, specifying the reasons that the plan contract
16 does not comply with the requirements of this chapter.

17 (b) At least 60 calendar days prior to offering a plan contract
18 subject to this article, all plans shall file a notice of material
19 modification with the director in accordance with the provisions
20 of Section 1352. The notice of material modification shall include
21 a statement certifying that the plan is in compliance with
22 subdivision (j) of Section 1357 and Section 1357.12. Plans that
23 will be offering to a small employer plan contracts approved by
24 the director prior to the effective date of this article shall file a
25 notice of material modification in accordance with this subdivision.
26 Any action by the director, as permitted under Section 1352, to
27 disapprove, suspend, or postpone the plan's use of a plan contract
28 shall be in writing, specifying the reasons that the plan contract
29 does not comply with the requirements of this chapter.

30 (c) Prior to making any changes in the risk categories or standard
31 employee risk rates filed with the director pursuant to subdivision
32 (a) or (b), the plan shall file as an amendment a statement setting
33 forth the changes and certifying that the plan is in compliance with
34 subdivision (j) of Section 1357 and Section 1357.12. A plan may
35 commence offering plan contracts utilizing the changed risk
36 categories set forth in the certified statement on the 31st day from
37 the date of the filing, or at an earlier time determined by the
38 director, unless the director disapproves the amendment by written
39 notice, stating the reasons therefor. If only the standard employee
40 risk rate is being changed, and not the risk categories, a plan may

1 commence offering plan contracts utilizing the changed standard
2 employee risk rate upon filing the certified statement unless the
3 director disapproves the amendment by written notice.

4 (d) Each plan shall maintain at its principal place of business
5 all of the information required to be filed with the director pursuant
6 to this section.

7 (e) Nothing in this section shall be construed to limit the
8 director's authority to enforce the rating practices set forth in this
9 article.

10 (f) This section shall become operative on January 1, 2014.

11 SEC. 10. Section 1357.50 of the Health and Safety Code is
12 amended to read:

13 1357.50. For purposes of this article:

14 (a) "Health benefit plan" means any individual or group
15 insurance policy or health care service plan contract that provides
16 medical, hospital, and surgical benefits. The term does not include
17 accident only, credit, disability income, coverage of Medicare
18 services pursuant to contracts with the United States government,
19 Medicare supplement, long-term care insurance, dental, vision,
20 coverage issued as a supplement to liability insurance, insurance
21 arising out of a workers' compensation or similar law, automobile
22 medical payment insurance, or insurance under which benefits are
23 payable with or without regard to fault and that is statutorily
24 required to be contained in any liability insurance policy or
25 equivalent self-insurance.

26 (b) "Late enrollee" means an eligible employee or dependent
27 who has declined health coverage under a health benefit plan
28 offered through employment or sponsored by an employer at the
29 time of the initial enrollment period provided under the terms of
30 the health benefit plan, and who subsequently requests enrollment
31 in a health benefit plan of that employer, provided that the initial
32 enrollment period shall be a period of at least 30 days. However,
33 an eligible employee or dependent shall not be considered a late
34 enrollee if any of the following is applicable:

35 (1) The individual meets all of the following requirements:

36 (A) The individual was covered under another employer health
37 benefit plan, the Healthy Families Program, the Access for Infants
38 and Mothers (AIM) Program, or the Medi-Cal program, at the time
39 the individual was eligible to enroll.

1 (B) The individual certified, at the time of the initial enrollment,
2 that coverage under another employer health benefit plan, the
3 Healthy Families Program, the AIM Program, or the Medi-Cal
4 program was the reason for declining enrollment provided that, if
5 the individual was covered under another employer health benefit
6 plan, the individual was given the opportunity to make the
7 certification required by this subdivision and was notified that
8 failure to do so could result in later treatment as a late enrollee.

9 (C) The individual has lost or will lose coverage under another
10 employer health benefit plan as a result of termination of
11 employment of the individual or of a person through whom the
12 individual was covered as a dependent, change in employment
13 status of the individual or of a person through whom the individual
14 was covered as a dependent, termination of the other plan's
15 coverage, cessation of an employer's contribution toward an
16 employee or dependent's coverage, death of a person through
17 whom the individual was covered as a dependent, legal separation,
18 or divorce; or the individual has lost or will lose coverage under
19 the Healthy Families Program, the AIM Program, or the Medi-Cal
20 program.

21 (D) The individual requests enrollment within 30 days after
22 termination of coverage, or cessation of employer contribution
23 toward coverage provided under another employer health benefit
24 plan, or requests enrollment within 60 days after termination of
25 Medi-Cal program coverage, AIM Program coverage, or Healthy
26 Families Program coverage.

27 (2) The individual is employed by an employer that offers
28 multiple health benefit plans and the individual elects a different
29 plan during an open enrollment period.

30 (3) A court has ordered that coverage be provided for a spouse
31 or minor child under a covered employee's health benefit plan.
32 The health benefit plan shall enroll a dependent child within 30
33 days after receipt of a court order or request from the district
34 attorney, either parent or the person having custody of the child
35 as defined in Section 3751.5 of the Family Code, the employer,
36 or the group administrator. In the case of children who are eligible
37 for Medicaid, the State Department of Health Care Services may
38 also make the request.

39 (4) The plan cannot produce a written statement from the
40 employer stating that, prior to declining coverage, the individual

1 or the person through whom the individual was eligible to be
2 covered as a dependent was provided with, and signed
3 acknowledgment of, explicit written notice in boldface type
4 specifying that failure to elect coverage during the initial
5 enrollment period permits the plan to impose, at the time of the
6 individual's later decision to elect coverage, an exclusion from
7 coverage for a period of 12 months as well as a six-month
8 preexisting condition exclusion, unless the individual meets the
9 criteria specified in paragraph (1), (2), or (3).

10 (5) The individual is an employee or dependent who meets the
11 criteria described in paragraph (1) and was under a COBRA
12 continuation provision, and the coverage under that provision has
13 been exhausted. For purposes of this section, the definition of
14 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
15 apply.

16 (6) The individual is a dependent of an enrolled eligible
17 employee who has lost or will lose his or her coverage under the
18 Healthy Families Program, the AIM Program, or the Medi-Cal
19 program, and requests enrollment within 60 days of termination
20 of that coverage.

21 (7) The individual is an eligible employee who previously
22 declined coverage under an employer health benefit plan and who
23 has subsequently acquired a dependent who would be eligible for
24 coverage as a dependent of the employee through marriage, birth,
25 adoption, or placement for adoption, and who enrolls for coverage
26 under that employer health benefit plan on his or her behalf, and
27 on behalf of his or her dependent within 30 days following the
28 date of marriage, birth, adoption, or placement for adoption, in
29 which case the effective date of coverage shall be the first day of
30 the month following the date the completed request for enrollment
31 is received in the case of marriage, or the date of birth, or the date
32 of adoption or placement for adoption, whichever applies. Notice
33 of the special enrollment rights contained in this paragraph shall
34 be provided by the employer to an employee at or before the time
35 the employee is offered an opportunity to enroll in plan coverage.

36 (8) The individual is an eligible employee who has declined
37 coverage for himself or herself or his or her dependents during a
38 previous enrollment period because his or her dependents were
39 covered by another employer health benefit plan at the time of the
40 previous enrollment period. That individual may enroll himself or

1 herself or his or her dependents for plan coverage during a special
2 open enrollment opportunity if his or her dependents have lost or
3 will lose coverage under that other employer health benefit plan.
4 The special open enrollment opportunity shall be requested by the
5 employee not more than 30 days after the date that the other health
6 coverage is exhausted or terminated. Upon enrollment, coverage
7 shall be effective not later than the first day of the first calendar
8 month beginning after the date the request for enrollment is
9 received. Notice of the special enrollment rights contained in this
10 paragraph shall be provided by the employer to an employee at or
11 before the time the employee is offered an opportunity to enroll
12 in plan coverage.

13 (c) ~~Until January 1, 2014~~ *December 31, 2013*, “preexisting
14 condition provision” means a contract provision that excludes
15 coverage for charges or expenses incurred during a specified period
16 following the enrollee’s effective date of coverage, as to a condition
17 for which medical advice, diagnosis, care, or treatment was
18 recommended or received during a specified period immediately
19 preceding the effective date of coverage.

20 (d) “Creditable coverage” means:

21 (1) Any individual or group policy, contract, or program that is
22 written or administered by a disability insurance company,
23 nonprofit hospital service plan, health care service plan, fraternal
24 benefits society, self-insured employer plan, or any other entity,
25 in this state or elsewhere, and that arranges or provides medical,
26 hospital, and surgical coverage not designed to supplement other
27 private or governmental plans. The term includes continuation or
28 conversion coverage but does not include accident only, credit,
29 coverage for onsite medical clinics, disability income, Medicare
30 supplement, long-term care insurance, dental, vision, coverage
31 issued as a supplement to liability insurance, insurance arising out
32 of a workers’ compensation or similar law, automobile medical
33 payment insurance, or insurance under which benefits are payable
34 with or without regard to fault and that is statutorily required to
35 be contained in any liability insurance policy or equivalent
36 self-insurance.

37 (2) The Medicare Program pursuant to Title XVIII of the federal
38 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

39 (3) The Medicaid Program pursuant to Title XIX of the federal
40 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e)~~ 300gg-3(c)).

(e) “Waivered condition” means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

(f) “Affiliation period” means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

(g) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 11. Section 1357.50 is added to the Health and Safety Code, to read:

1357.50. For purposes of this article:

(a) “Health benefit plan” means any individual or group insurance policy or health care service plan contract that provides essential health benefits as defined consistent with Section 1302 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement,

1 long-term care insurance, dental, vision, coverage issued as a
2 supplement to liability insurance, insurance arising out of a
3 workers' compensation or similar law, automobile medical payment
4 insurance, or insurance under which benefits are payable with or
5 without regard to fault and that is statutorily required to be
6 contained in any liability insurance policy or equivalent
7 self-insurance. The term does not include a grandfathered plan as
8 defined in Section 1251 of the federal Patient Protection and
9 Affordable Care Act (Public Law 111-148).

10 (b) "Late enrollee" means an eligible employee or dependent
11 who has declined health coverage under a health benefit plan
12 offered through employment or sponsored by an employer at the
13 time of the initial enrollment period provided under the terms of
14 the health benefit plan, and who subsequently requests enrollment
15 in a health benefit plan of that employer, provided that the initial
16 enrollment period shall be a period of at least 30 days. However,
17 an eligible employee or dependent shall not be considered a late
18 enrollee if any of the following is applicable:

19 (1) The individual meets all of the following requirements:

20 (A) The individual was covered under another employer health
21 benefit plan, the Healthy Families Program, the Access for Infants
22 and Mothers (AIM) Program, the Medi-Cal program, or the
23 California Health Benefit Exchange, at the time the individual was
24 eligible to enroll.

25 (B) The individual certified, at the time of the initial enrollment,
26 that coverage under another employer health benefit plan, the
27 Healthy Families Program, the AIM Program, the Medi-Cal
28 program, or the California Health Benefit Exchange was the reason
29 for declining enrollment provided that, if the individual was
30 covered under another employer health benefit plan, the individual
31 was given the opportunity to make the certification required by
32 this subdivision and was notified that failure to do so could result
33 in later treatment as a late enrollee.

34 (C) The individual has lost or will lose coverage under another
35 employer health benefit plan as a result of termination of
36 employment of the individual or of a person through whom the
37 individual was covered as a dependent, change in employment
38 status of the individual or of a person through whom the individual
39 was covered as a dependent, termination of the other plan's
40 coverage, cessation of an employer's contribution toward an

1 employee or dependent's coverage, death of a person through
2 whom the individual was covered as a dependent, legal separation,
3 or divorce; or the individual has lost or will lose coverage under
4 the Healthy Families Program, the AIM Program, the Medi-Cal
5 program, or the California Health Benefit Exchange.

6 (D) The individual requests enrollment within 30 days after
7 termination of coverage, or cessation of employer contribution
8 toward coverage provided under another employer health benefit
9 plan, or requests enrollment within 60 days after termination of
10 Medi-Cal program coverage, AIM Program coverage, Healthy
11 Families Program coverage, or coverage through the California
12 Health Benefit Exchange.

13 (2) The individual is employed by an employer that offers
14 multiple health benefit plans and the individual elects a different
15 plan during an open enrollment period.

16 (3) A court has ordered that coverage be provided for a spouse
17 or minor child under a covered employee's health benefit plan.
18 The health benefit plan shall enroll a dependent child within 30
19 days after receipt of a court order or request from the district
20 attorney, either parent or the person having custody of the child
21 as defined in Section 3751.5 of the Family Code, the employer,
22 or the group administrator. In the case of children who are eligible
23 for Medicaid, the State Department of Health Care Services may
24 also make the request.

25 (4) The plan cannot produce a written statement from the
26 employer stating that, prior to declining coverage, the individual
27 or the person through whom the individual was eligible to be
28 covered as a dependent was provided with, and signed
29 acknowledgment of, explicit written notice in boldface type
30 specifying that failure to elect coverage during the initial
31 enrollment period permits the plan to impose, at the time of the
32 individual's later decision to elect coverage, an exclusion from
33 coverage for a period of 12 months as well as a six-month
34 preexisting condition exclusion, unless the individual meets the
35 criteria specified in paragraph (1), (2), or (3).

36 (5) The individual is an employee or dependent who meets the
37 criteria described in paragraph (1) and was under a COBRA
38 continuation provision, and the coverage under that provision has
39 been exhausted. For purposes of this section, the definition of

1 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
2 apply.

3 (6) The individual is a dependent of an enrolled eligible
4 employee who has lost or will lose his or her coverage under the
5 Healthy Families Program, the AIM Program, the Medi-Cal
6 program, or the California Health Benefit Exchange, and requests
7 enrollment within 60 days of termination of that coverage.

8 (7) The individual is an eligible employee who previously
9 declined coverage under an employer health benefit plan and who
10 has subsequently acquired a dependent who would be eligible for
11 coverage as a dependent of the employee through marriage, birth,
12 adoption, or placement for adoption, and who enrolls for coverage
13 under that employer health benefit plan on his or her behalf, and
14 on behalf of his or her dependent within 30 days following the
15 date of marriage, birth, adoption, or placement for adoption, in
16 which case the effective date of coverage shall be the first day of
17 the month following the date the completed request for enrollment
18 is received in the case of marriage, or the date of birth, or the date
19 of adoption or placement for adoption, whichever applies. Notice
20 of the special enrollment rights contained in this paragraph shall
21 be provided by the employer to an employee at or before the time
22 the employee is offered an opportunity to enroll in plan coverage.

23 (8) The individual is an eligible employee who has declined
24 coverage for himself or herself or his or her dependents during a
25 previous enrollment period because his or her dependents were
26 covered by another employer health benefit plan at the time of the
27 previous enrollment period. That individual may enroll himself or
28 herself or his or her dependents for plan coverage during a special
29 open enrollment opportunity if his or her dependents have lost or
30 will lose coverage under that other employer health benefit plan.
31 The special open enrollment opportunity shall be requested by the
32 employee not more than 30 days after the date that the other health
33 coverage is exhausted or terminated. Upon enrollment, coverage
34 shall be effective not later than the first day of the first calendar
35 month beginning after the date the request for enrollment is
36 received. Notice of the special enrollment rights contained in this
37 paragraph shall be provided by the employer to an employee at or
38 before the time the employee is offered an opportunity to enroll
39 in plan coverage.

1 (c) On or after January 1, 2014, a plan contract shall not establish
2 any preexisting condition exclusion or limitation for any individual
3 or dependent of an individual, whether or not any medical advice,
4 diagnosis, care, or treatment was recommended or received before
5 that date. A preexisting condition exclusion includes any limitation
6 or exclusion of benefits, including a denial of coverage, applicable
7 to an individual as a result of information relating to an individual's
8 health status before the individual's effective date of coverage
9 under a group health plan, or group or individual health insurance
10 coverage, such as a condition identified as a result of a
11 preenrollment questionnaire or physical examination given to the
12 individual, or review of medical records relating to the
13 preenrollment period.

14 (d) "Creditable coverage" means:

15 (1) Any individual or group policy, contract, or program that is
16 written or administered by a disability insurance company,
17 nonprofit hospital service plan, health care service plan, fraternal
18 benefits society, self-insured employer plan, or any other entity,
19 in this state or elsewhere, and that arranges or provides medical,
20 hospital, and surgical coverage not designed to supplement other
21 private or governmental plans. The term includes continuation or
22 conversion coverage but does not include accident only, credit,
23 coverage for onsite medical clinics, disability income, Medicare
24 supplement, long-term care insurance, dental, vision, coverage
25 issued as a supplement to liability insurance, insurance arising out
26 of a workers' compensation or similar law, automobile medical
27 payment insurance, or insurance under which benefits are payable
28 with or without regard to fault and that is statutorily required to
29 be contained in any liability insurance policy or equivalent
30 self-insurance.

31 (2) The Medicare Program pursuant to Title XVIII of the federal
32 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

33 (3) The Medicaid Program pursuant to Title XIX of the federal
34 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

35 (4) Any other publicly sponsored program, provided in this state
36 or elsewhere, of medical, hospital, and surgical care.

37 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
38 (Civilian Health and Medical Program of the Uniformed Services
39 (CHAMPUS)).

1 (6) A medical care program of the Indian Health Service or of
2 a tribal organization.

3 (7) A state health benefits risk pool.

4 (8) A health plan offered under 5 U.S.C. Chapter 89
5 (commencing with Section 8901) (Federal Employees Health
6 Benefits Program (FEHBP)).

7 (9) A public health plan as defined in federal regulations
8 authorized by Section 2701(c)(1)(I) of the Public Health Service
9 Act, as amended by Public Law 104-191, the Health Insurance
10 Portability and Accountability Act of 1996.

11 (10) A health benefit plan under Section 5(e) of the Peace Corps
12 Act (22 U.S.C. Sec. 2504(e)).

13 (11) Any other creditable coverage as defined by subdivision
14 (c) of Section 2701 of Title XXVII of the federal Public Health
15 Service Act (42 U.S.C. Sec. ~~300gg(e)~~ 300gg-3(c)).

16 (e) This section shall become operative on January 1, 2014.

17 SEC. 12. Section 1357.51 of the Health and Safety Code is
18 amended to read:

19 1357.51. (a) ~~Until January 1, 2014~~ *December 31, 2013*, no
20 plan contract that covers three or more enrollees shall exclude
21 coverage for any individual on the basis of a preexisting condition
22 provision for a period greater than six months following the
23 individual's effective date of coverage. Preexisting condition
24 provisions contained in plan contracts may relate only to conditions
25 for which medical advice, diagnosis, care, or treatment, including
26 use of prescription drugs, was recommended or received from a
27 licensed health practitioner during the six months immediately
28 preceding the effective date of coverage.

29 (b) ~~Until January 1, 2014~~ *December 31, 2013*, no plan contract
30 that covers one or two individuals shall exclude coverage on the
31 basis of a preexisting condition provision for a period greater than
32 12 months following the individual's effective date of coverage,
33 nor shall the plan limit or exclude coverage for a specific enrollee
34 by type of illness, treatment, medical condition, or accident, except
35 for satisfaction of a preexisting condition clause pursuant to this
36 article. Preexisting condition provisions contained in plan contracts
37 may relate only to conditions for which medical advice, diagnosis,
38 care, or treatment, including use of prescription drugs, was
39 recommended or received from a licensed health practitioner during

1 the 12 months immediately preceding the effective date of
2 coverage.

3 (c) (1) Notwithstanding subdivision (a), a plan contract for
4 group coverage shall not impose any preexisting condition
5 provision upon any child under 19 years of age.

6 (2) Notwithstanding subdivision (b), a plan contract for
7 individual coverage that is not a grandfathered health plan within
8 the meaning of Section 1251 of the federal Patient Protection and
9 Affordable Care Act (Public Law 111-148) shall not impose any
10 preexisting condition provision upon any child under 19 years of
11 age.

12 (d) ~~Until January 1, 2014~~ *December 31, 2013*, a plan that does
13 not utilize a preexisting condition provision may impose a waiting
14 or affiliation period not to exceed 60 days, before the coverage
15 issued subject to this article shall become effective. During the
16 waiting or affiliation period, the plan is not required to provide
17 health care services and no premium shall be charged to the
18 subscriber or enrollee.

19 (e) ~~Until January 1, 2014~~ *December 31, 2013*, a plan that does
20 not utilize a preexisting condition provision in plan contracts that
21 cover one or two individuals may impose a contract provision
22 excluding coverage for waived conditions. No plan may exclude
23 coverage on the basis of a waived condition for a period greater
24 than 12 months following the individual's effective date of
25 coverage. A waived condition provision contained in plan
26 contracts may relate only to conditions for which medical advice,
27 diagnosis, care, or treatment, including use of prescription drugs,
28 was recommended or received from a licensed health practitioner
29 during the 12 months immediately preceding the effective date of
30 coverage.

31 (f) ~~Until January 1, 2014~~ *December 31, 2013*, in determining
32 whether a preexisting condition provision, a waived condition
33 provision, or a waiting or affiliation period applies to any enrollee,
34 a plan shall credit the time the enrollee was covered under
35 creditable coverage, provided that the enrollee becomes eligible
36 for coverage under the succeeding plan contract within 62 days of
37 termination of prior coverage, exclusive of any waiting or
38 affiliation period, and applies for coverage under the succeeding
39 plan within the applicable enrollment period. A plan shall also
40 credit any time that an eligible employee must wait before enrolling

1 in the plan, including any postenrollment or employer-imposed
2 waiting or affiliation period.

3 However, if a person's employment has ended, the availability
4 of health coverage offered through employment or sponsored by
5 an employer has terminated, or an employer's contribution toward
6 health coverage has terminated, a plan shall credit the time the
7 person was covered under creditable coverage if the person
8 becomes eligible for health coverage offered through employment
9 or sponsored by an employer within 180 days, exclusive of any
10 waiting or affiliation period, and applies for coverage under the
11 succeeding plan contract within the applicable enrollment period.

12 (g) ~~Until January 1, 2014~~ *December 31, 2013*, no plan shall
13 exclude late enrollees from coverage for more than 12 months
14 from the date of the late enrollee's application for coverage. No
15 plan shall require any premium or other periodic charge to be paid
16 by or on behalf of a late enrollee during the period of exclusion
17 from coverage permitted by this subdivision.

18 (h) A health care service plan issuing group coverage may not
19 impose a preexisting condition exclusion upon a condition relating
20 to benefits for pregnancy or maternity care.

21 (i) An individual's period of creditable coverage shall be
22 certified pursuant to subsection (e) of Section 2701 of Title XXVII
23 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e)~~
24 *300gg-3(e)*).

25 (j) This section shall remain in effect only until January 1, 2014,
26 and as of that date is repealed, unless a later enacted statute, that
27 is enacted before January 1, 2014, deletes or extends that date.

28 SEC. 13. Section 1357.51 is added to the Health and Safety
29 Code, to read:

30 1357.51. (a) No plan contract that covers one or more enrollees
31 shall exclude coverage for any individual on the basis of a
32 preexisting condition.

33 (b) (1) A plan contract for group coverage shall not impose any
34 preexisting condition provision upon any individual.

35 (2) A plan contract for individual coverage that is not a
36 grandfathered health plan within the meaning of Section 1251 of
37 the federal Patient Protection and Affordable Care Act (Public
38 Law 111-148) shall not impose any preexisting condition provision
39 upon any individual.

(c) A plan may impose a 90-day waiting period from the date of the late enrollee's application for coverage. *A plan contract may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees and if consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

(d) A health care service plan issuing group coverage may not impose a preexisting condition exclusion based on health status-related factors, including, but not limited to, the following:

- (1) Health status.
- (2) Medical condition, including both physical and mental illnesses.
- (3) Claims experience.
- (4) Receipt of medical care.
- (5) Medical history.
- (6) Genetic information.
- (7) Evidence of insurability, including conditions arising from domestic violence.
- (8) Disability.
- (9) Any other health status-related factor determined appropriate by the federal government.
- (10) Any other health status-related factor determined appropriate by the director.

(e) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e)~~ *300gg-3(e)*).

(f) This section shall become operative on January 1, 2014.

SEC. 14. Section 1357.52 of the Health and Safety Code is amended to read:

1357.52. (a) ~~Until January 1, 2014~~ *December 31, 2013*, except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a plan may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability including conditions arising

1 out of acts of domestic violence of that employee or dependent.
2 No plan contract may limit or exclude coverage for a specific
3 eligible employee or dependent by type of illness, treatment,
4 medical condition, or accident, except for preexisting conditions
5 as permitted by Section 1357.06.

6 (b) On or after January 1, 2014, a plan may not exclude any
7 eligible employee or dependent who would otherwise ~~by~~ *be* entitled
8 to health care services on the basis of any of the following: the
9 health status, the medical condition, including both physical and
10 mental illnesses, the claims experience, the medical history, the
11 genetic information, or the disability or evidence of insurability,
12 including conditions arising out of acts of domestic violence, of
13 that employee or dependent. No plan contract may limit or exclude
14 coverage for a specific eligible employee or dependent by type of
15 illness, treatment, medical condition, or accident.

16 (c) This section shall remain in effect only until January 1, 2014,
17 and as of that date is repealed, unless a later enacted statute, that
18 is enacted before January 1, 2014, deletes or extends that date.

19 SEC. 15. Section 1357.52 is added to the Health and Safety
20 Code, to read:

21 1357.52. A plan may not exclude any eligible employee or
22 dependent who would otherwise be entitled to health care services
23 on the basis of any of the following: the health status, the medical
24 condition, including both physical and mental illnesses, the claims
25 experience, the medical history, the genetic information, or the
26 disability or evidence of insurability including conditions arising
27 out of acts of domestic violence of that employee or dependent.
28 No plan contract may limit or exclude coverage for a specific
29 eligible employee or dependent by type of illness, treatment,
30 medical condition, or accident.

31 This section shall become operative on January 1, 2014.

32 *SEC. 15.5. Section 106 of the Insurance Code is amended to*
33 *read:*

34 106. (a) Disability insurance includes insurance appertaining
35 to injury, disablement or death resulting to the insured from
36 accidents, and appertaining to disablements resulting to the insured
37 from sickness.

38 (b) In statutes that become effective on or after January 1, 2002,
39 the term "health insurance" for purposes of this code shall mean
40 an individual or group disability insurance policy that provides

1 coverage for hospital, medical, or surgical benefits. The term
2 “health insurance” shall not include any of the following kinds of
3 insurance:

4 (1) Accidental death and accidental death and dismemberment.

5 (2) Disability insurance, including hospital indemnity, accident
6 only, and specified disease insurance that pays benefits on a fixed
7 benefit, cash payment only basis.

8 (3) Credit disability, as defined in subdivision (2) of Section
9 779.2.

10 (4) Coverage issued as a supplement to liability insurance.

11 (5) Disability income, as defined in subdivision (i) of Section
12 799.01.

13 (6) Insurance under which benefits are payable with or without
14 regard to fault and that is statutorily required to be contained in
15 any liability insurance policy or equivalent self-insurance.

16 (7) Insurance arising out of a workers’ compensation or similar
17 law.

18 (8) Long-term care.

19 (c) In a statute that becomes effective on or after January 1,
20 2008, the term “specialized health insurance policy” as used in
21 this code shall mean a policy of health insurance for covered
22 benefits in a single specialized area of health care, including
23 dental-only, vision-only, and behavioral health-only policies.

24 (d) *In a statute that becomes effective on or after January 1,*
25 *2014, the term “health insurance” for purposes of this code shall*
26 *mean an individual or group disability insurance policy that*
27 *provides essential health benefits consistent with Section 1302 of*
28 *the federal Patient Protection and Affordable Care Act (Public*
29 *Law 111-148) and regulations adopted pursuant thereto. This*
30 *shall not apply to coverage that is grandfathered coverage*
31 *consistent with Section 1251 of the federal Patient Protection and*
32 *Affordable Care Act (Public Law 111-148).*

33 SEC. 16. Section 10198.6 of the Insurance Code is amended
34 to read:

35 10198.6. For purposes of this article:

36 (a) “Health benefit plan” means any group or individual policy
37 or contract that provides medical, hospital, or surgical benefits.
38 The term does not include accident only, credit, disability income,
39 coverage of Medicare services pursuant to contracts with the United
40 States government, Medicare supplement, long-term care insurance,

1 dental, vision, coverage issued as a supplement to liability
2 insurance, insurance arising out of a workers' compensation or
3 similar law, automobile medical payment insurance, or insurance
4 under which benefits are payable with or without regard to fault
5 and that is statutorily required to be contained in any liability
6 insurance policy or equivalent self-insurance.

7 (b) "Late enrollee" means an eligible employee or dependent
8 who has declined health coverage under a health benefit plan
9 offered through employment or sponsored by an employer at the
10 time of the initial enrollment period provided under the terms of
11 the health benefit plan, and who subsequently requests enrollment
12 in a health benefit plan of that employer, provided that the initial
13 enrollment period shall be a period of at least 30 days. However,
14 an eligible employee or dependent shall not be considered a late
15 enrollee if any of the following is applicable:

16 (1) The individual meets all of the following requirements:

17 (A) The individual was covered under another employer health
18 benefit plan, the Healthy Families Program, the Access for Infants
19 and Mothers (AIM) Program, or the Medi-Cal program, at the time
20 the individual was eligible to enroll.

21 (B) The individual certified, at the time of the initial enrollment,
22 that coverage under another employer health benefit plan, the
23 Healthy Families Program, the AIM Program, or the Medi-Cal
24 program was the reason for declining enrollment provided that, if
25 the individual was covered under another employer health benefit
26 plan, the individual was given the opportunity to make the
27 certification required by this subdivision and was notified that
28 failure to do so could result in later treatment as a late enrollee.

29 (C) The individual has lost or will lose coverage under another
30 employer health benefit plan as a result of termination of
31 employment of the individual or of a person through whom the
32 individual was covered as a dependent, change in employment
33 status of the individual or of a person through whom the individual
34 was covered as a dependent, termination of the other plan's
35 coverage, cessation of an employer's contribution toward an
36 employee or dependent's coverage, death of a person through
37 whom the individual was covered as a dependent, legal separation,
38 or divorce; or the individual has lost or will lose coverage under
39 the Healthy Families Program, the AIM Program, or the Medi-Cal
40 program.

1 (D) The individual requests enrollment within 30 days after
2 termination of coverage, or cessation of employer contribution
3 toward coverage provided under another employer health benefit
4 plan, or requests enrollment within 60 days after termination of
5 Medi-Cal program coverage, AIM Program coverage, or Healthy
6 Families Program coverage.

7 (2) The individual is employed by an employer that offers
8 multiple health benefit plans and the individual elects a different
9 plan during an open enrollment period.

10 (3) A court has ordered that coverage be provided for a spouse
11 or minor child under a covered employee's health benefit plan.

12 (4) The carrier cannot produce a written statement from the
13 employer stating that, prior to declining coverage, the individual
14 or the person through whom the individual was eligible to be
15 covered as a dependent was provided with, and signed
16 acknowledgment of, explicit written notice in boldface type
17 specifying that failure to elect coverage during the initial
18 enrollment period permits the carrier to impose, at the time of the
19 individual's later decision to elect coverage, an exclusion from
20 coverage for a period of 12 months as well as a six-month
21 preexisting condition exclusion, unless the individual meets the
22 criteria specified in paragraph (1), (2), or (3).

23 (5) The individual is an employee or dependent who meets the
24 criteria described in paragraph (1) and was under a COBRA
25 continuation provision and the coverage under that provision has
26 been exhausted. For purposes of this section, the definition of
27 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
28 apply.

29 (6) The individual is a dependent of an enrolled eligible
30 employee who has lost or will lose his or her coverage under the
31 Healthy Families Program, the AIM Program, or the Medi-Cal
32 program, and requests enrollment within 60 days of termination
33 of that coverage.

34 (c) ~~Until January 1, 2014~~ *December 31, 2013*, "preexisting
35 condition provision" means a policy provision that excludes
36 coverage for charges or expenses incurred during a specified period
37 following the insured's effective date of coverage, as to a condition
38 for which medical advice, diagnosis, care, or treatment was
39 recommended or received during a specified period immediately
40 preceding the effective date of coverage.

(d) “Creditable coverage” means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(3) The Medicaid Program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the federal Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e))~~ 300gg-3(c)).

(e) “Affiliation period” means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

(f) “Waivered condition” means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

(g) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 17. Section 10198.6 is added to the Insurance Code, to read:

10198.6. For purposes of this article:

(a) “Health benefit plan” means any group or individual policy or contract that provides essential health benefits as defined consistent with Section 1302 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) “Late enrollee” means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, the Medi-Cal program, or the

1 California Health Benefit Exchange, at the time the individual was
2 eligible to enroll.

3 (B) The individual certified, at the time of the initial enrollment,
4 that coverage under another employer health benefit plan, the
5 Healthy Families Program, the AIM Program, the Medi-Cal
6 program, or the California Health Benefit Exchange was the reason
7 for declining enrollment provided that, if the individual was
8 covered under another employer health benefit plan, the individual
9 was given the opportunity to make the certification required by
10 this subdivision and was notified that failure to do so could result
11 in later treatment as a late enrollee.

12 (C) The individual has lost or will lose coverage under another
13 employer health benefit plan as a result of termination of
14 employment of the individual or of a person through whom the
15 individual was covered as a dependent, change in employment
16 status of the individual or of a person through whom the individual
17 was covered as a dependent, termination of the other plan's
18 coverage, cessation of an employer's contribution toward an
19 employee or dependent's coverage, death of a person through
20 whom the individual was covered as a dependent, legal separation,
21 or divorce; or the individual has lost or will lose coverage under
22 the Healthy Families Program, the AIM Program, the Medi-Cal
23 program, or the California Health Benefit Exchange.

24 (D) The individual requests enrollment within 30 days after
25 termination of coverage, or cessation of employer contribution
26 toward coverage provided under another employer health benefit
27 plan, or requests enrollment within 60 days after termination of
28 Medi-Cal program coverage, AIM Program coverage, Healthy
29 Families Program coverage, or coverage through the California
30 Health Benefit Exchange.

31 (2) The individual is employed by an employer that offers
32 multiple health benefit plans and the individual elects a different
33 plan during an open enrollment period.

34 (3) A court has ordered that coverage be provided for a spouse
35 or minor child under a covered employee's health benefit plan.

36 (4) The carrier cannot produce a written statement from the
37 employer stating that, prior to declining coverage, the individual
38 or the person through whom the individual was eligible to be
39 covered as a dependent was provided with, and signed
40 acknowledgment of, explicit written notice in boldface type

1 specifying that failure to elect coverage during the initial
2 enrollment period permits the carrier to impose, at the time of the
3 individual's later decision to elect coverage, an exclusion from
4 coverage for a period of 12 months as well as a six-month
5 preexisting condition exclusion, unless the individual meets the
6 criteria specified in paragraph (1), (2), or (3).

7 (5) The individual is an employee or dependent who meets the
8 criteria described in paragraph (1) and was under a COBRA
9 continuation provision and the coverage under that provision has
10 been exhausted. For purposes of this section, the definition of
11 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
12 apply.

13 (6) The individual is a dependent of an enrolled eligible
14 employee who has lost or will lose his or her coverage under the
15 Healthy Families Program, the AIM Program, the Medi-Cal
16 program, or the California Health Benefit Exchange, and requests
17 enrollment within 60 days of termination of that coverage.

18 (c) On or after January 1, 2014, a policy shall not establish any
19 preexisting condition exclusion or limitation for any individual or
20 dependent of an individual, whether or not any medical advice,
21 diagnosis, care, or treatment was recommended or received before
22 that date. A preexisting condition exclusion includes any limitation
23 or exclusion of benefits, including a denial of coverage, applicable
24 to an individual as a result of information relating to an individual's
25 health status before the individual's effective date of coverage
26 under a group health plan, or group or individual health insurance
27 coverage, such as a condition identified as a result of a
28 preenrollment questionnaire or physical examination given to the
29 individual, or review of medical records relating to the
30 preenrollment period.

31 (d) "Creditable coverage" means:

32 (1) Any individual or group policy, contract or program, that is
33 written or administered by a disability insurance company, health
34 care service plan, fraternal benefits society, self-insured employer
35 plan, or any other entity, in this state or elsewhere, and that
36 arranges or provides medical, hospital, and surgical coverage not
37 designed to supplement other private or governmental plans. The
38 term includes continuation or conversion coverage but does not
39 include accident only, credit, coverage for onsite medical clinics,
40 disability income, Medicare supplement, long-term care insurance,

1 dental, vision, coverage issued as a supplement to liability
2 insurance, insurance arising out of a workers' compensation or
3 similar law, automobile medical payment insurance, or insurance
4 under which benefits are payable with or without regard to fault
5 and that is statutorily required to be contained in any liability
6 insurance policy or equivalent self-insurance.

7 (2) The federal Medicare Program pursuant to Title XVIII of
8 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

9 (3) The Medicaid Program pursuant to Title XIX of the federal
10 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

11 (4) Any other publicly sponsored program, provided in this state
12 or elsewhere, of medical, hospital, and surgical care.

13 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
14 (Civilian Health and Medical Program of the Uniformed Services
15 (CHAMPUS)).

16 (6) A medical care program of the Indian Health Service or of
17 a tribal organization.

18 (7) A state health benefits risk pool.

19 (8) A health plan offered under 5 U.S.C. Chapter 89
20 (commencing with Section 8901) (Federal Employees Health
21 Benefits Program (FEHBP)).

22 (9) A public health plan as defined in federal regulations
23 authorized by Section 2701(c)(1)(I) of the federal Public Health
24 Service Act, as amended by Public Law 104-191, the federal Health
25 Insurance Portability and Accountability Act of 1996.

26 (10) A health benefit plan under Section 5(e) of the federal
27 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

28 (11) Any other creditable coverage as defined by subsection (c)
29 of Section 2701 of Title XXVII of the federal Public Health Service
30 Act (42 U.S.C. Sec. 300gg(e)) 300gg-3(c)).

31 (e) This section shall become operative on January 1, 2014.

32 SEC. 18. Section 10198.7 of the Insurance Code is amended
33 to read:

34 10198.7. (a) ~~Until January 1, 2014~~ *December 31, 2013*, no
35 health benefit plan that covers three or more persons and that is
36 issued, renewed, or written by any insurer, nonprofit hospital
37 service plan, self-insured employee welfare benefit plan, fraternal
38 benefits society, or any other entity shall exclude coverage for any
39 individual on the basis of a preexisting condition provision for a
40 period greater than six months following the individual's effective

1 date of coverage, nor shall limit or exclude coverage for a specific
2 insured person by type of illness, treatment, medical condition, or
3 accident except for satisfaction of a preexisting clause pursuant to
4 this article. Preexisting condition provisions contained in health
5 benefit plans may relate only to conditions for which medical
6 advice, diagnosis, care, or treatment, including use of prescription
7 drugs, was recommended or received from a licensed health
8 practitioner during the six months immediately preceding the
9 effective date of coverage.

10 (b) ~~Until January 1, 2014~~ *December 31, 2013*, no health benefit
11 plan that covers one or two individuals and that is issued, renewed,
12 or written by any insurer, self-insured employee welfare benefit
13 plan, fraternal benefits society, or any other entity shall exclude
14 coverage on the basis of a preexisting condition provision for a
15 period greater than 12 months following the individual's effective
16 date of coverage, nor shall limit or exclude coverage for a specific
17 insured person by type of illness, treatment, medical condition, or
18 accident, except for satisfaction of a preexisting condition clause
19 pursuant to this article. Preexisting condition provisions contained
20 in health benefit plans may relate only to conditions for which
21 medical advice, diagnosis, care, or treatment, including use of
22 prescription drugs, was recommended or received from a licensed
23 health practitioner during the 12 months immediately preceding
24 the effective date of coverage.

25 (c) (1) Notwithstanding subdivision (a), a health benefit plan
26 for group coverage shall not impose any preexisting condition
27 provision upon any child under 19 years of age.

28 (2) Notwithstanding subdivision (b), a health benefit plan for
29 individual coverage that is a grandfathered plan within the meaning
30 of Section 1251 of the federal Patient Protection and Affordable
31 Care Act (Public Law 111-148) shall not impose any preexisting
32 condition provision upon any child under 19 years of age.

33 (d) ~~Until January 1, 2014~~ *December 31, 2013*, a carrier that does
34 not utilize a preexisting condition provision may impose a waiting
35 or affiliation period not to exceed 60 days, before the coverage
36 issued subject to this article shall become effective. During the
37 waiting or affiliation period, the carrier is not required to provide
38 health care services and no premium shall be charged to the
39 subscriber or enrollee.

1 (e) Until ~~January 1, 2014~~ *December 31, 2013*, a carrier that does
2 not utilize a preexisting condition provision in health plans that
3 cover one or two individuals may impose a contract provision
4 excluding coverage for waived conditions. No carrier may
5 exclude coverage on the basis of a waived condition for a period
6 greater than 12 months following the individual's effective date
7 of coverage. A waived condition provision contained in health
8 benefit plans may relate only to conditions for which medical
9 advice, diagnosis, care, or treatment, including use of prescription
10 drugs, was recommended or received from a licensed health
11 practitioner during the 12 months immediately preceding the
12 effective date of coverage.

13 (f) Until ~~January 1, 2014~~ *December 31, 2013*, in determining
14 whether a preexisting condition provision, a waived condition
15 provision, or a waiting or affiliation period applies to any person,
16 all health benefit plans shall credit the time the person was covered
17 under creditable coverage, provided the person becomes eligible
18 for coverage under the succeeding health benefit plan within 62
19 days of termination of prior coverage, exclusive of any waiting or
20 affiliation period, and applies for coverage under the succeeding
21 plan within the applicable enrollment period. A health benefit plan
22 shall also credit any time an eligible employee must wait before
23 enrolling in the health benefit plan, including any affiliation or
24 employer-imposed waiting period. However, if a person's
25 employment has ended, the availability of health coverage offered
26 through employment or sponsored by an employer has terminated
27 or, an employer's contribution toward health coverage has
28 terminated, a carrier shall credit the time the person was covered
29 under creditable coverage if the person becomes eligible for health
30 coverage offered through employment or sponsored by an employer
31 within 180 days, exclusive of any waiting or affiliation period, and
32 applies for coverage under the succeeding plan within the
33 applicable enrollment period.

34 (g) Until ~~January 1, 2014~~ *December 31, 2013*, no health benefit
35 plan that covers three or more persons and that is issued, renewed,
36 or written by any insurer, nonprofit hospital service plan,
37 self-insured employee welfare benefit plan, fraternal benefits
38 society, or any other entity may exclude late enrollees from
39 coverage for more than 12 months from the date of the late
40 enrollee's application for coverage. No insurer, nonprofit hospital

1 service plan, self-insured employee welfare benefit plan, fraternal
2 benefits society, or any other entity shall require any premium or
3 other periodic charge to be paid by or on behalf of a late enrollee
4 during the period of exclusion from coverage permitted by this
5 subdivision.

6 (h) An individual's period of creditable coverage shall be
7 certified pursuant to subsection (e) of Section 2701 of Title XXVII
8 of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e)~~
9 *300gg-3(e)*).

10 (i) A group health benefit plan may not impose a preexisting
11 condition exclusion to a condition relating to benefits for pregnancy
12 or maternity care.

13 (j) Any entity providing aggregate or specific stop loss coverage
14 or any other assumption of risk with reference to a health benefit
15 plan shall provide that the plan meets all requirements of this article
16 concerning waiting periods, preexisting condition provisions, and
17 late enrollees.

18 (k) This section shall remain in effect only until January 1, 2014,
19 and as of that date is repealed, unless a later enacted statute, that
20 is enacted before January 1, 2014, deletes or extends that date.

21 SEC. 19. Section 10198.7 is added to the Insurance Code, to
22 read:

23 10198.7. (a) No health benefit plan that covers one or more
24 enrollees shall exclude coverage for any individual on the basis
25 of a preexisting condition.

26 (b) (1) A health benefit plan for group coverage shall not impose
27 any preexisting condition provision upon any individual.

28 (2) A health benefit plan for individual coverage that is a
29 grandfathered plan within the meaning of Section 1251 of the
30 federal Patient Protection and Affordable Care Act (Public Law
31 111-148) shall not impose any preexisting condition provision
32 upon any individual.

33 (c) A health benefit plan may impose a 90-day waiting period
34 from the date of the late enrollee's application for coverage. *A*
35 *group health benefit plan may permit a waiting period of up to 90*
36 *days as a condition of enrollment if applied equally to all full-time*
37 *employees and if consistent with the federal Patient Protection*
38 *and Affordable Care Act (Public Law 111-148) and any rules,*
39 *regulations, or guidance issued consistent with that law.*

(d) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. ~~300gg(e)~~ 300gg-3(e)).

(e) A group health benefit plan may not impose a preexisting condition exclusion based on health status-related factors, including, but not limited to, the following:

(1) Health status.

(2) Medical condition, including both physical and mental illnesses.

(3) Claims experience.

(4) Receipt of medical care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising from domestic violence.

(8) Disability.

(9) Any other health status-related factor determined appropriate by the federal government.

(10) Any other health status-related factor determined appropriate by the commissioner.

(f) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

(g) This section shall become operative on January 1, 2014.

SEC. 20. Section 10198.9 of the Insurance Code is amended to read:

10198.9. (a) (1) ~~Until January 1, 2014~~ *December 31, 2013*, except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage

1 for a specific eligible employee or dependent by type of illness,
2 treatment, medical condition, or accident, except for preexisting
3 conditions as permitted by Section 10198.7.

4 (2) On or after January 1, 2014, a health insurer may not exclude
5 any eligible employee or dependent who would otherwise ~~by~~ *be*
6 entitled to health care services on the basis of any of the following:
7 the health status, the medical condition, including both physical
8 and mental illnesses, the claims experience, the medical history,
9 the genetic information, or the disability or evidence of insurability
10 including conditions arising out of acts of domestic violence of
11 that employee or dependent. No health benefit plan may limit or
12 exclude coverage for a specific eligible employee or dependent
13 by type of illness, treatment, medical condition, or accident.

14 (b) For purposes of this section, “health benefit plan” shall have
15 the same meaning as in Section 10198.6 and subdivision (a) of
16 Section 10198.61.

17 (c) For purposes of this section, “eligible employee” shall have
18 the same meaning as in Section 10700 except that it shall apply to
19 any health benefit plan covering one or more eligible employees.

20 (d) This section shall remain in effect only until January 1, 2014,
21 and as of that date is repealed, unless a later enacted statute, that
22 is enacted before January 1, 2014, deletes or extends that date.

23 SEC. 21. Section 10198.9 is added to the Insurance Code, to
24 read:

25 10198.9. (a) A health insurer may not exclude any eligible
26 employee or dependent who would otherwise be entitled to health
27 care services on the basis of any of the following: the health status,
28 the medical condition, including both physical and mental illnesses,
29 the claims experience, the medical history, the genetic information,
30 or the disability or evidence of insurability including conditions
31 arising out of acts of domestic violence of that employee or
32 dependent. No health benefit plan may limit or exclude coverage
33 for a specific eligible employee or dependent by type of illness,
34 treatment, medical condition, or accident.

35 (b) For purposes of this section, “health benefit plan” shall have
36 the same meaning as in Section 10198.6 and subdivision (a) of
37 Section 10198.61.

38 (c) For purposes of this section, “eligible employee” shall have
39 the same meaning as in Section 10700 except that it shall apply to
40 any health benefit plan covering one or more eligible employees.

1 (d) This section shall become operative on January 1, 2014.

2 SEC. 22. Section 10700 of the Insurance Code is amended to
3 read:

4 10700. As used in this chapter:

5 (a) “Agent or broker” means a person or entity licensed under
6 Chapter 5 (commencing with Section 1621) of Part 2 of Division
7 1.

8 (b) “Benefit plan design” means a specific health coverage
9 product issued by a carrier to small employers, to trustees of
10 associations that include small employers, or to individuals if the
11 coverage is offered through employment or sponsored by an
12 employer. It includes services covered and the levels of copayment
13 and deductibles, and it may include the professional providers who
14 are to provide those services and the sites where those services are
15 to be provided. A benefit plan design may also be an integrated
16 system for the financing and delivery of quality health care services
17 which has significant incentives for the covered individuals to use
18 the system.

19 (c) “Board” means the Major Risk Medical Insurance Board.

20 (d) “Carrier” means any disability insurance company or any
21 other entity that writes, issues, or administers health benefit plans
22 that cover the employees of small employers, regardless of the
23 situs of the contract or master policyholder. For the purposes of
24 Articles 3 (commencing with Section 10719) and 4 (commencing
25 with Section 10730), “carrier” also includes health care service
26 plans.

27 (e) “Dependent” means the spouse or child of an eligible
28 employee, subject to applicable terms of the health benefit plan
29 covering the employee, and includes dependents of guaranteed
30 association members if the association elects to include dependents
31 under its health coverage at the same time it determines its
32 membership composition pursuant to subdivision (z).

33 (f) “Eligible employee” means either of the following:

34 (1) Any permanent employee who is actively engaged on a
35 full-time basis in the conduct of the business of the small employer
36 with a normal workweek of an average of 30 hours per week over
37 the course of a month, in the small employer’s regular place of
38 business, who has met any statutorily authorized applicable waiting
39 period requirements. The term includes sole proprietors or partners
40 of a partnership, if they are actively engaged on a full-time basis

1 in the small employer's business, and they are included as
2 employees under a health benefit plan of a small employer, but
3 does not include employees who work on a part-time, temporary,
4 or substitute basis. It includes any eligible employee, as defined
5 in this paragraph, who obtains coverage through a guaranteed
6 association. Employees of employers purchasing through a
7 guaranteed association shall be deemed to be eligible employees
8 if they would otherwise meet the definition except for the number
9 of persons employed by the employer. A permanent employee
10 who works at least 20 hours but not more than 29 hours is deemed
11 to be an eligible employee if all four of the following apply:

12 (A) The employee otherwise meets the definition of an eligible
13 employee except for the number of hours worked.

14 (B) The employer offers the employee health coverage under a
15 health benefit plan.

16 (C) All similarly situated individuals are offered coverage under
17 the health benefit plan.

18 (D) The employee must have worked at least 20 hours per
19 normal workweek for at least 50 percent of the weeks in the
20 previous calendar quarter. The insurer may request any necessary
21 information to document the hours and time period in question,
22 including, but not limited to, payroll records and employee wage
23 and tax filings.

24 (2) Any member of a guaranteed association as defined in
25 subdivision (z).

26 (g) "Enrollee" means an eligible employee or dependent who
27 receives health coverage through the program from a participating
28 carrier.

29 (h) "Financially impaired" means, for the purposes of this
30 chapter, a carrier that, on or after the effective date of this chapter,
31 is not insolvent and is either:

32 (1) Deemed by the commissioner to be potentially unable to
33 fulfill its contractual obligations.

34 (2) Placed under an order of rehabilitation or conservation by
35 a court of competent jurisdiction.

36 (i) "Fund" means the California Small Group Reinsurance Fund.

37 (j) "Health benefit plan" means a policy or contract written or
38 administered by a carrier that arranges or provides health care
39 benefits for the covered eligible employees of a small employer
40 and their dependents. The term does not include accident only,

1 credit, disability income, coverage of Medicare services pursuant
2 to contracts with the United States government, Medicare
3 supplement, long-term care insurance, dental, vision, coverage
4 issued as a supplement to liability insurance, automobile medical
5 payment insurance, or insurance under which benefits are payable
6 with or without regard to fault and that is statutorily required to
7 be contained in any liability insurance policy or equivalent
8 self-insurance.

9 (k) “In force business” means an existing health benefit plan
10 issued by the carrier to a small employer.

11 (l) “Late enrollee” means an eligible employee or dependent
12 who has declined health coverage under a health benefit plan
13 offered by a small employer at the time of the initial enrollment
14 period provided under the terms of the health benefit plan and who
15 subsequently requests enrollment in a health benefit plan of that
16 small employer, provided that the initial enrollment period shall
17 be a period of at least 30 days. It also means any member of an
18 association that is a guaranteed association as well as any other
19 person eligible to purchase through the guaranteed association
20 when that person has failed to purchase coverage during the initial
21 enrollment period provided under the terms of the guaranteed
22 association’s health benefit plan and who subsequently requests
23 enrollment in the plan, provided that the initial enrollment period
24 shall be a period of at least 30 days. However, an eligible
25 employee, another person eligible for coverage through a
26 guaranteed association pursuant to subdivision (z), or an eligible
27 dependent shall not be considered a late enrollee if any of the
28 following is applicable:

29 (1) The individual meets all of the following requirements:

30 (A) He or she was covered under another employer health
31 benefit plan, the Healthy Families Program, the Access for Infants
32 and Mothers (AIM) Program, ~~or~~ the Medi-Cal program, or the
33 California Health Benefit Exchange, at the time the individual was
34 eligible to enroll.

35 (B) He or she certified at the time of the initial enrollment that
36 coverage under another employer health benefit plan, the Healthy
37 Families Program, the AIM Program, the Medi-Cal program, or
38 the California Health Benefit Exchange was the reason for
39 declining enrollment provided that, if the individual was covered
40 under another employer health plan, the individual was given the

1 opportunity to make the certification required by this subdivision
2 and was notified that failure to do so could result in later treatment
3 as a late enrollee.

4 (C) He or she has lost or will lose coverage under another
5 employer health benefit plan as a result of termination of
6 employment of the individual or of a person through whom the
7 individual was covered as a dependent, change in employment
8 status of the individual, or of a person through whom the individual
9 was covered as a dependent, the termination of the other plan's
10 coverage, cessation of an employer's contribution toward an
11 employee or dependent's coverage, death of the person through
12 whom the individual was covered as a dependent, legal separation,
13 or divorce; or he or she has lost or will lose coverage under the
14 Healthy Families Program, the AIM Program, the Medi-Cal
15 program, or the California Health Benefit Exchange.

16 (D) He or she requests enrollment within 30 days after
17 termination of coverage or employer contribution toward coverage
18 provided under another employer health benefit plan, or requests
19 enrollment within 60 days after termination of Medi-Cal program
20 coverage, AIM Program coverage, Healthy Families Program
21 coverage, or coverage through the California Health Benefit
22 Exchange.

23 (2) The individual is employed by an employer who offers
24 multiple health benefit plans and the individual elects a different
25 plan during an open enrollment period.

26 (3) A court has ordered that coverage be provided for a spouse
27 or minor child under a covered employee's health benefit plan.

28 (4) (A) ~~In~~ *Until December 31, 2013, in* the case of an eligible
29 employee as defined in paragraph (1) of subdivision (f), the carrier
30 cannot produce a written statement from the employer stating that
31 the individual or the person through whom an individual was
32 eligible to be covered as a dependent, prior to declining coverage,
33 was provided with, and signed acknowledgment of, an explicit
34 written notice in boldface type specifying that failure to elect
35 coverage during the initial enrollment period permits the carrier
36 to impose, at the time of the individual's later decision to elect
37 coverage, an exclusion from coverage for a period of 12 months
38 as well as a six-month preexisting condition exclusion unless the
39 individual meets the criteria specified in paragraph (1), (2), or (3).

1 (B) ~~In~~ *Until December 31, 2013*, in the case of an eligible
2 employee who is a guaranteed association member, the plan cannot
3 produce a written statement from the guaranteed association stating
4 that the association sent a written notice in boldface type to all
5 potentially eligible association members at their last known address
6 prior to the initial enrollment period informing members that failure
7 to elect coverage during the initial enrollment period permits the
8 plan to impose, at the time of the member's later decision to elect
9 coverage, an exclusion from coverage for a period of 12 months
10 as well as a six-month preexisting condition exclusion unless the
11 member can demonstrate that he or she meets the requirements of
12 subparagraphs (A), (C), and (D) of paragraph (1) or meets the
13 requirements of paragraph (2) or (3).

14 (C) In the case of an employer or person who is not a member
15 of an association, was eligible to purchase coverage through a
16 guaranteed association, and did not do so, and would not be eligible
17 to purchase guaranteed coverage unless purchased through a
18 guaranteed association, the employer or person can demonstrate
19 that he or she meets the requirements of subparagraphs (A), (C),
20 and (D) of paragraph (1), or meets the requirements of paragraph
21 (2) or (3), or that he or she recently had a change in status that
22 would make him or her eligible and that application for coverage
23 was made within 30 days of the change.

24 (5) The individual is an employee or dependent who meets the
25 criteria described in paragraph (1) and was under a COBRA
26 continuation provision and the coverage under that provision has
27 been exhausted. For purposes of this section, the definition of
28 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
29 apply.

30 (6) The individual is a dependent of an enrolled eligible
31 employee who has lost or will lose his or her coverage under the
32 Healthy Families Program, the AIM Program, the Medi-Cal
33 program, or the California Health Benefit Exchange, and requests
34 enrollment within 60 days after termination of that coverage.

35 (7) The individual is an eligible employee who previously
36 declined coverage under an employer health benefit plan and who
37 has subsequently acquired a dependent who would be eligible for
38 coverage as a dependent of the employee through marriage, birth,
39 adoption, or placement for adoption, and who enrolls for coverage
40 under that employer health benefit plan on his or her behalf and

1 on behalf of his or her dependent within 30 days following the
2 date of marriage, birth, adoption, or placement for adoption, in
3 which case the effective date of coverage shall be the first day of
4 the month following the date the completed request for enrollment
5 is received in the case of marriage, or the date of birth, or the date
6 of adoption or placement for adoption, whichever applies. Notice
7 of the special enrollment rights contained in this paragraph shall
8 be provided by the employer to an employee at or before the time
9 the employee is offered an opportunity to enroll in plan coverage.

10 (8) The individual is an eligible employee who has declined
11 coverage for himself or herself or his or her dependents during a
12 previous enrollment period because his or her dependents were
13 covered by another employer health benefit plan at the time of the
14 previous enrollment period. That individual may enroll himself or
15 herself or his or her dependents for plan coverage during a special
16 open enrollment opportunity if his or her dependents have lost or
17 will lose coverage under that other employer health benefit plan.
18 The special open enrollment opportunity shall be requested by the
19 employee not more than 30 days after the date that the other health
20 coverage is exhausted or terminated. Upon enrollment, coverage
21 shall be effective not later than the first day of the first calendar
22 month beginning after the date the request for enrollment is
23 received. Notice of the special enrollment rights contained in this
24 paragraph shall be provided by the employer to an employee at or
25 before the time the employee is offered an opportunity to enroll
26 in plan coverage.

27 (m) “New business” means a health benefit plan issued to a
28 small employer that is not the carrier’s in force business.

29 (n) “Participating carrier” means a carrier that has entered into
30 a contract with the program to provide health benefits coverage
31 under this part.

32 (o) “Plan of operation” means the plan of operation of the fund,
33 including articles, bylaws, and operating rules adopted by the fund
34 pursuant to Article 3 (commencing with Section 10719).

35 (p) “Program” means the Health Insurance Plan of California.

36 (q) (1) ~~Until January 1, 2014~~ *December 31, 2013*, “preexisting
37 condition provision” means a policy provision that excludes
38 coverage for charges or expenses incurred during a specified period
39 following the insured’s effective date of coverage, as to a condition
40 for which medical advice, diagnosis, care, or treatment was

1 recommended or received during a specified period immediately
2 preceding the effective date of coverage.

3 (2) On and after January 1, 2014, no insurer shall limit or
4 exclude coverage for any individual based on a preexisting
5 condition whether or not any medical advice, diagnosis, care, or
6 treatment was recommended or received before that date.

7 (r) "Creditable coverage" means:

8 (1) Any individual or group policy, contract, or program, that
9 is written or administered by a disability insurer, health care service
10 plan, fraternal benefits society, self-insured employer plan, or any
11 other entity, in this state or elsewhere, and that arranges or provides
12 medical, hospital, and surgical coverage not designed to supplement
13 other private or governmental plans. The term includes continuation
14 or conversion coverage but does not include accident only, credit,
15 coverage for onsite medical clinics, disability income, Medicare
16 supplement, long-term care, dental, vision, coverage issued as a
17 supplement to liability insurance, insurance arising out of a
18 workers' compensation or similar law, automobile medical payment
19 insurance, or insurance under which benefits are payable with or
20 without regard to fault and that is statutorily required to be
21 contained in any liability insurance policy or equivalent
22 self-insurance.

23 (2) The federal Medicare Program pursuant to Title XVIII of
24 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

25 (3) The Medicaid Program pursuant to Title XIX of the federal
26 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

27 (4) Any other publicly sponsored program, provided in this state
28 or elsewhere, of medical, hospital, and surgical care.

29 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
30 (Civilian Health and Medical Program of the Uniformed Services
31 (CHAMPUS)).

32 (6) A medical care program of the Indian Health Service or of
33 a tribal organization.

34 (7) A state health benefits risk pool.

35 (8) A health plan offered under 5 U.S.C. Chapter 89
36 (commencing with Section 8901) (Federal Employees Health
37 Benefits Program (FEHBP)).

38 (9) A public health plan as defined in federal regulations
39 authorized by Section 2701(c)(1)(I) of the federal Public Health

1 Service Act, as amended by Public Law 104-191, the federal Health
2 Insurance Portability and Accountability Act of 1996.

3 (10) A health benefit plan under Section 5(e) of the federal
4 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

5 (11) Any other creditable coverage as defined by subsection (c)
6 of Section 2701 of Title XXVII of the federal Public Health Service
7 Act (42 U.S.C. Sec. ~~300gg(e)~~ 300gg-3(c)).

8 (s) "Rating period" means the period for which premium rates
9 established by a carrier are in effect and shall be no less than 12
10 months.

11 (t) "Risk adjusted employee risk rate" means the rate determined
12 for an eligible employee of a small employer in a particular risk
13 category after applying the risk adjustment factor.

14 (u) "Risk adjustment factor" means the percent adjustment to
15 be applied equally to each standard employee risk rate for a
16 particular small employer, based upon any expected deviations
17 from standard claims. This factor may not be more than 120 percent
18 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
19 this factor may not be more than 110 percent or less than 90
20 percent. Effective January 1, 2014, ~~the risk adjustment factor shall~~
21 ~~be zero~~ *no risk adjustment factor shall be used in the determination*
22 *of rates.*

23 (v) "Risk category" means the following characteristics of an
24 eligible employee: age, geographic region, and family size of the
25 employee, plus the benefit plan design selected by the small
26 employer *to the extent permitted under the federal Patient*
27 *Protection and Affordable Care Act (Public Law 111-148) and*
28 *any rules, regulations, or guidance issued consistent with that law.*

29 (1) No more than the following age categories may be used in
30 determining premium rates:

31 Under 30

32 30-39

33 40-49

34 50-54

35 55-59

36 60-64

37 65 and over

38 However, for the 65 and over age category, separate premium
39 rates may be specified depending upon whether coverage under
40 the health benefit plan will be primary or secondary to benefits

1 provided by the federal Medicare Program pursuant to Title XVIII
2 of the federal Social Security Act. Effective January 1, 2014, the
3 rate for age shall not vary by more than three to one for adults.

4 (2) Small employer carriers shall base rates to small employers
5 using no more than the following family size categories:

6 (A) Single.

7 (B) Married couple.

8 (C) One adult and child or children.

9 (D) Married couple and child or children.

10 (3) (A) In determining rates for small employers, a carrier that
11 operates statewide shall use no more than nine geographic regions
12 in the state, have no region smaller than an area in which the first
13 three digits of all its ZIP Codes are in common within a county,
14 and shall divide no county into more than two regions. Carriers
15 shall be deemed to be operating statewide if their coverage area
16 includes 90 percent or more of the state's population. Geographic
17 regions established pursuant to this section shall, as a group, cover
18 the entire state, and the area encompassed in a geographic region
19 shall be separate and distinct from areas encompassed in other
20 geographic regions. Geographic regions may be noncontiguous.

21 (B) In determining rates for small employers, a carrier that does
22 not operate statewide shall use no more than the number of
23 geographic regions in the state than is determined by the following
24 formula: the population, as determined in the last federal census,
25 of all counties which are included in their entirety in a carrier's
26 service area divided by the total population of the state, as
27 determined in the last federal census, multiplied by nine. The
28 resulting number shall be rounded to the nearest whole integer.
29 No region may be smaller than an area in which the first three
30 digits of all its ZIP Codes are in common within a county and no
31 county may be divided into more than two regions. The area
32 encompassed in a geographic region shall be separate and distinct
33 from areas encompassed in other geographic regions. Geographic
34 regions may be noncontiguous. No carrier shall have less than one
35 geographic area.

36 (w) "Small employer" means either of the following:

37 (1) ~~Until January 1, 2014~~ *December 31, 2013*, any person,
38 proprietary or nonprofit firm, corporation, partnership, public
39 agency, or association that is actively engaged in business or
40 service that, on at least 50 percent of its working days during the

1 preceding calendar quarter, or preceding calendar year, employed
2 at least 2, but not more than 50, eligible employees, the majority
3 of whom were employed within this state, that was not formed
4 primarily for purposes of buying health insurance and in which a
5 bona fide employer-employee relationship exists. On or after
6 January 1, 2014, and until December 31, ~~2016~~ 2015, any person,
7 firm, proprietary or nonprofit corporation, partnership, public
8 agency, or association that is actively engaged in business or
9 service, that, on at least 50 percent of its working days during the
10 preceding calendar quarter or preceding calendar year, employed
11 at least one, but no more than 50, eligible employees, the majority
12 of whom were employed within this state, that was not formed
13 primarily for purposes of buying health insurance, and in which a
14 bona fide employer-employee relationship exists. On or after
15 January 1, ~~2017~~ 2016, any person, firm, proprietary or nonprofit
16 corporation, partnership, public agency, or association that is
17 actively engaged in business or service, that, on at least 50 percent
18 of its working days during the preceding calendar quarter or
19 preceding calendar year, employed at least one, but no more than
20 100, eligible employees, the majority of whom were employed
21 within this state, that was not formed primarily for purposes of
22 buying health benefit plans, and in which a bona fide
23 employer-employee relationship exists. In determining whether
24 to apply the calendar quarter or calendar year test, the insurer shall
25 use the test that ensures eligibility if only one test would establish
26 eligibility. In determining the number of eligible employees,
27 companies that are affiliated companies and that are eligible to file
28 a combined income tax return for purposes of state taxation shall
29 be considered one employer. Subsequent to the issuance of a health
30 benefit plan to a small employer pursuant to this chapter, and for
31 the purpose of determining eligibility, the size of a small employer
32 shall be determined annually. Except as otherwise specifically
33 provided, provisions of this chapter that apply to a small employer
34 shall continue to apply until the health benefit plan anniversary
35 following the date the employer no longer meets the requirements
36 of this definition. It includes any small employer as defined in this
37 paragraph who purchases coverage through a guaranteed
38 association, and any employer purchasing coverage for employees
39 through a guaranteed association. *This paragraph shall be*
40 *implemented to the extent consistent with the federal Patient*

Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

(2) Any guaranteed association, as defined in subdivision (y), that purchases health coverage for members of the association.

(3) On or after January 1, 2014, a self-employed individual who obtains at least 50 percent of annual income from self-employment as demonstrated through personal income tax filings for the current or prior year. To the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules or guidance issued consistent with that law, a self-employed individual whose modified annual gross income is anticipated to be less than 400 percent of the federal poverty level may at his or her discretion seek to enroll as an individual rather than a small employer through the California Health Benefit Exchange *to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

(x) “Standard employee risk rate” means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(y) “Guaranteed association” means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any

1 member choosing to enroll in the benefit plan design offered to
2 the association provided that the member has agreed to make the
3 required premium payments, and (10) covers at least 1,000 persons
4 with the carrier with which it contracts. The requirement of 1,000
5 persons may be met if component chapters of a statewide
6 association contracting separately with the same carrier cover at
7 least 1,000 persons in the aggregate.

8 This subdivision applies regardless of whether a master policy
9 by an admitted insurer is delivered directly to the association or a
10 trust formed for or sponsored by an association to administer
11 benefits for association members.

12 For purposes of this subdivision, an association formed by a
13 merger of two or more associations after January 1, 1992, and
14 otherwise meeting the criteria of this subdivision shall be deemed
15 to have been in active existence on January 1, 1992, if its
16 predecessor organizations had been in active existence on January
17 1, 1992, and for at least five years prior to that date and otherwise
18 met the criteria of this subdivision.

19 (z) “Members of a guaranteed association” means any individual
20 or employer meeting the association’s membership criteria if that
21 person is a member of the association and chooses to purchase
22 health coverage through the association. At the association’s
23 discretion, it may also include employees of association members,
24 association staff, retired members, retired employees of members,
25 and surviving spouses and dependents of deceased members.
26 However, if an association chooses to include those persons as
27 members of the guaranteed association, the association must so
28 elect in advance of purchasing coverage from a plan. Health plans
29 may require an association to adhere to the membership
30 composition it selects for up to 12 months.

31 (aa) “Affiliation period” means a period that, under the terms
32 of the health benefit plan, must expire before health care services
33 under the plan become effective *until December 31, 2013*.

34 SEC. 23. Section 10705 of the Insurance Code is amended to
35 read:

36 10705. Upon the effective date of this act:

37 (a) No group or individual policy or contract or certificate of
38 group insurance or statement of group coverage providing benefits
39 to employees of small employers as defined in this chapter shall
40 be issued or delivered by a carrier subject to the jurisdiction of the

1 commissioner regardless of the situs of the contract or master
2 policyholder or of the domicile of the carrier nor, except as
3 otherwise provided in Sections 10270.91 and 10270.92, shall a
4 carrier provide coverage subject to this chapter until a copy of the
5 form of the policy, contract, certificate, or statement of coverage
6 is filed with and approved by the commissioner in accordance with
7 Sections 10290 and 10291, and the carrier has complied with the
8 requirements of Section 10717.

9 (b) (1) Each carrier, except a self-funded employer, shall fairly
10 and affirmatively offer, market, and sell all of the carrier's benefit
11 plan designs that are sold to, offered through, or sponsored by,
12 small employers or associations that include small employers to
13 all small employers in each geographic region in which the carrier
14 makes coverage available or provides benefits.

15 (2) A carrier contracting to participate in the California Health
16 Benefit Exchange shall be deemed to be in compliance with
17 paragraph (1) for a benefit plan design offered in those geographic
18 regions in which the carrier participates in the California Health
19 Benefit Exchange.

20 (3) (A) A carrier shall be deemed to meet the requirements of
21 paragraph (1) and subdivision (c) with respect to a benefit plan
22 design that qualifies as a grandfathered health plan under Section
23 1251 of PPACA if all of the following requirements are met:

24 (i) The carrier offers to renew the benefit plan design, unless
25 the carrier withdraws the benefit plan design from the small
26 employer market pursuant to subdivision (e) of Section 10713.

27 (ii) The carrier provides appropriate notice of the grandfathered
28 status of the benefit plan design in any materials provided to an
29 insured of the design describing the benefits provided under the
30 design, as required under PPACA.

31 (iii) The carrier makes no changes to the benefits covered under
32 the benefit plan design other than those required by a state or
33 federal law, regulation, rule, or guidance and those permitted to
34 be made to a grandfathered health plan under PPACA.

35 (B) For purposes of this paragraph, "PPACA" means the federal
36 Patient Protection and Affordable Care Act (Public Law 111-148),
37 as amended by the federal Health Care and Education
38 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
39 regulations, or guidance issued thereunder. For purposes of this

1 paragraph, a “grandfathered health plan” shall have the meaning
2 set forth in Section 1251 of PPACA.

3 (4) Nothing in this section shall be construed to require an
4 association, or a trust established and maintained by an association
5 to receive a master insurance policy issued by an admitted insurer
6 and to administer the benefits thereof solely for association
7 members, to offer, market or sell a benefit plan design to those
8 who are not members of the association. However, if the
9 association markets, offers or sells a benefit plan design to those
10 who are not members of the association it is subject to the
11 requirements of this section. This shall apply to an association that
12 otherwise meets the requirements of paragraph (8) formed by
13 merger of two or more associations after January 1, 1992, if the
14 predecessor organizations had been in active existence on January
15 1, 1992, and for at least five years prior to that date and met the
16 requirements of paragraph (5).

17 (5) A carrier which (A) effective January 1, 1992, and at least
18 20 years prior to that date, markets, offers, or sells benefit plan
19 designs only to all members of one association and (B) does not
20 market, offer or sell any other individual, selected group, or group
21 policy or contract providing medical, hospital, and surgical benefits
22 shall not be required to market, offer, or sell to those who are not
23 members of the association. However, if the carrier markets, offers
24 or sells any benefit plan design or any other individual, selected
25 group, or group policy or contract providing medical, hospital and
26 surgical benefits to those who are not members of the association
27 it is subject to the requirements of this section.

28 (6) Each carrier that sells health benefit plans to members of
29 one association pursuant to paragraph (5) shall submit an annual
30 statement to the commissioner which states that the carrier is selling
31 health benefit plans pursuant to paragraph (5) and which, for the
32 one association, lists all the information required by paragraph (7).

33 (7) Each carrier that sells health benefit plans to members of
34 any association shall submit an annual statement to the
35 commissioner which lists each association to which the carrier
36 sells health benefit plans, the industry or profession which is served
37 by the association, the association’s membership criteria, a list of
38 officers, the state in which the association is organized, and the
39 site of its principal office.

(8) For purposes of paragraphs (4) and (5), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(c) Each carrier shall make available to each small employer all benefit plan designs that the carrier offers or sells to small employers or to associations that include small employers. Notwithstanding subdivision (d) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(d) Each carrier shall do all of the following:

(1) Prepare a brochure that summarizes all of its benefit plan designs and make this summary available to small employers, agents and brokers upon request. The summary shall include for each benefit plan design information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, and, until January 1, 2014, an explanation of how creditable coverage is calculated if a preexisting condition or affiliation period is imposed, ~~and~~. The summary shall also include a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send

1 copies to agents and brokers representing the carrier. Any entity
2 that provides administrative services only with regard to a benefit
3 plan design written or issued by another carrier shall not be
4 required to prepare a summary brochure which includes that benefit
5 plan design.

6 (2) For each benefit plan design, prepare a more detailed
7 evidence of coverage and make it available to small employers,
8 agents and brokers upon request. The evidence of coverage shall
9 contain all information that a prudent buyer would need to be aware
10 of in making selections of benefit plan designs. An entity that
11 provides administrative services only with regard to a benefit plan
12 design written or issued by another carrier shall not be required to
13 prepare an evidence of coverage for that benefit plan design.

14 (3) Provide to small employers, agents, and brokers, upon
15 request, for any given small employer the sum of the standard
16 employee risk rates and the sum of the risk adjusted standard
17 employee risk rates. When requesting this information, small
18 employers, agents and brokers shall provide the carrier with the
19 information the carrier needs to determine the small employer's
20 risk adjusted employee risk rate.

21 (4) Provide copies of the current summary brochure to all agents
22 or brokers who represent the carrier and, upon updating the
23 brochure, send copies of the updated brochure to agents and brokers
24 representing the carrier for the purpose of selling health benefit
25 plans.

26 (5) Notwithstanding subdivision (d) of Section 10700, for
27 purposes of this subdivision, companies that are affiliated
28 companies or that are eligible to file a consolidated income tax
29 return shall be treated as one carrier.

30 (e) Every agent or broker representing one or more carriers for
31 the purpose of selling health benefit plans to small employers shall
32 do all of the following:

33 (1) When providing information on a health benefit plan to a
34 small employer but making no specific recommendations on
35 particular benefit plan designs:

36 (A) Advise the small employer of the carrier's obligation to sell
37 to any small employer any of the benefit plan designs it offers to
38 small employers and provide them, upon request, with the actual
39 rates that would be charged to that employer for a given benefit
40 plan design.

1 (B) Notify the small employer that the agent or broker will
2 procure rate and benefit information for the small employer on
3 any benefit plan design offered by a carrier for whom the agent or
4 broker sells health benefit plans.

5 (C) Notify the small employer that, upon request, the agent or
6 broker will provide the small employer with the summary brochure
7 required in paragraph (1) of subdivision (d) for any benefit plan
8 design offered by a carrier whom the agent or broker represents.

9 (D) Notify the small employer of the availability of coverage
10 through the California Health Benefit Exchange *and the availability*
11 *of tax credits for certain employers, and effective January 1, 2014,*
12 *the availability of tax credits through the Exchange.*

13 (2) When recommending a particular benefit plan design or
14 designs, advise the small employer that, upon request, the agent
15 will provide the small employer with the brochure required by
16 paragraph (1) of subdivision (d) containing the benefit plan design
17 or designs being recommended by the agent or broker.

18 (3) Prior to filing an application for a small employer for a
19 particular health benefit plan:

20 (A) For each of the benefit plan designs offered by the carrier
21 whose benefit plan design the agent or broker is presenting, provide
22 the small employer with the benefit summary required in paragraph
23 (1) of subdivision (d) and the sum of the standard employee risk
24 rates for that particular employer.

25 (B) Notify the small employer that, upon request, the agent or
26 broker will provide the small employer with an evidence of
27 coverage brochure for each benefit plan design the carrier offers.

28 (C) ~~Until January 1, 2014~~ *December 31, 2013*, notify the small
29 employer that actual rates may be 10 percent higher or lower than
30 the sum of the standard employee risk rates depending on how the
31 carrier assesses the risk of the small employer's group.

32 (D) ~~Until January 1, 2014~~ *December 31, 2013*, notify the small
33 employer that, upon request, the agent or broker will submit
34 information to the carrier to ascertain the small employer's sum
35 of the risk adjusted standard employee risk rate for any benefit
36 plan design the carrier offers. On or after July 1, 2013, notify the
37 small employer of the employee rate effective January 1, 2014.

38 (E) Obtain a signed statement from the small employer
39 acknowledging that the small employer has received the disclosures
40 required by this paragraph and Section 10716.

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10700, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section ~~17000~~ 10700, is provided in connection with a guaranteed association.

(g) No carrier shall reject an application from a small employer for a benefit plan design provided:

(1) The small employer as defined by paragraph (1) of subdivision (w) of Section 10700 offers health benefits to 100 percent of its eligible employees as defined in paragraph (1) of subdivision (f) of Section 10700. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(h) No carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(2) Encourage or direct small employers to seek coverage from another carrier or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(i) ~~(1)~~ No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer or the small employer's employees. This ~~paragraph~~ subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the

1 percentage shall not vary because of the health status, claims
2 experience, industry, occupation, or geographic area of the small
3 employer.

4 ~~(2) On and after January 1, 2014, an agent or broker shall not,~~
5 ~~directly or indirectly, enter into any contract, agreement, or~~
6 ~~arrangement with a carrier that provides for or results in the~~
7 ~~compensation paid to an agent or broker for the sale of a health~~
8 ~~benefit plan to be varied because of the health status, claims~~
9 ~~experience, industry, occupation, or geographic location of the~~
10 ~~small employer or the small employer's employees. This paragraph~~
11 ~~does not apply to a compensation arrangement that provides~~
12 ~~compensation to an agent or broker on the basis of percentage of~~
13 ~~premium, provided that the percentage shall not vary because of~~
14 ~~the health status, claims experience, industry, occupation, or~~
15 ~~geographic area of the small employer.~~

16 ~~(3) On and after January 1, 2013, a carrier shall file with the~~
17 ~~department any and all compensation agreements with agents and~~
18 ~~brokers so that the department may monitor for compliance with~~
19 ~~this section.~~

20 (j) Except in the case of a late insured, or for satisfaction of a
21 preexisting condition clause in the case of initial coverage of an
22 eligible employee, a disability insurer may not exclude any eligible
23 employee or dependent who would otherwise be entitled to health
24 care services on the basis of any of the following: the health status,
25 the medical condition, including both physical and mental illnesses,
26 the claims experience, the medical history, the genetic information,
27 the disability or evidence of insurability, including conditions
28 arising out of acts of domestic violence of that employee or
29 dependent, or any other health status-related factor as determined
30 by the department. No health benefit plan may limit or exclude
31 coverage for a specific eligible employee or dependent by type of
32 illness, treatment, medical condition, or accident, except for
33 preexisting conditions as permitted by Section 10198.7 or 10708.

34 (k) If a carrier enters into a contract, agreement, or other
35 arrangement with a third-party administrator or other entity to
36 provide administrative, marketing, or other services related to the
37 offering of health benefit plans to small employers in this state,
38 the third-party administrator shall be subject to this chapter.

39 (l) (1) With respect to the obligation to provide coverage newly
40 issued under subdivision (d), the carrier may cease enrolling new

1 small employer groups and new eligible employees as defined by
2 paragraph (2) of subdivision (f) of Section 10700 if it certifies to
3 the commissioner that the number of eligible employees and
4 dependents, of the employers newly enrolled or insured during the
5 current calendar year by the carrier equals or exceeds: (A) in the
6 case of a carrier that administers any self-funded health benefits
7 arrangement in California, 10 percent of the total number of eligible
8 employees, or eligible employees and dependents, respectively,
9 enrolled or insured in California by that carrier as of December
10 31 of the preceding year, or (B) in the case of a carrier that does
11 not administer any self-funded health benefit arrangements in
12 California, 8 percent of the total number of eligible employees, or
13 eligible employees and dependents, respectively, enrolled or
14 insured by the carrier in California as of December 31 of the
15 preceding year.

16 (2) Certification shall be deemed approved if not disapproved
17 within 45 days after submission to the commissioner. If that
18 certification is approved, the small employer carrier shall not offer
19 coverage to any small employers under any health benefit plans
20 during the remainder of the current year. If the certification is not
21 approved, the carrier shall continue to issue coverage as required
22 by subdivision (d) and be subject to administrative penalties as
23 established in Section 10718.

24 SEC. 24. Section 10706 of the Insurance Code is amended to
25 read:

26 10706. Every carrier shall file with the commissioner the
27 reasonable participation requirements and employer contribution
28 requirements that are to be included in its health benefit plans.
29 Participation requirements shall be applied uniformly among all
30 small employer groups, except that a carrier may vary application
31 of minimum employer participation requirements by the size of
32 the small employer group and whether the employer contributes
33 100 percent of the eligible employee's premium. Employer
34 contribution requirements shall not vary by employer size.
35 Employer contribution requirements shall be consistent with the
36 federal Patient Protection and Affordable Care Act (Public Law
37 111-148). A carrier shall not establish a participation requirement
38 that (1) requires a person who meets the definition of a dependent
39 in subdivision (e) of Section 10700 to enroll as a dependent if he
40 or she is otherwise eligible for coverage and wishes to enroll as

1 an eligible employee and (2) allows a carrier to reject an otherwise
2 eligible small employer because of the number of persons that
3 waive coverage due to coverage through another employer.
4 Members of an association eligible for health coverage eligible
5 under subdivision (z) of Section 10700 but not electing any health
6 coverage through the association shall not be counted as eligible
7 employees for purposes of determining whether the guaranteed
8 association meets a carrier's reasonable participation standards.

9 SEC. 25. Section 10707 of the Insurance Code is amended to
10 read:

11 10707. (a) ~~Until January 1, 2014~~ *December 31, 2013*, except
12 in the case of a late enrollee, or for satisfaction of a preexisting
13 condition clause in the case of initial coverage of an eligible
14 employee, a carrier may not exclude any eligible employee or
15 dependent who would otherwise be covered, on the basis of an
16 actual or expected health condition of that employee or dependent.
17 No health benefit plan may limit or exclude coverage for a specific
18 eligible employee or dependent by type of illness, treatment,
19 medical condition, or accident, except for preexisting conditions
20 as permitted by Section 10708.

21 (b) On or after January 1, 2014, a carrier may not exclude any
22 eligible employee or dependent who would otherwise be entitled
23 to health care services on the basis of an actual or expected health
24 condition of that employee or dependent. No health benefit plan
25 may limit or exclude coverage for a specific eligible employee or
26 dependent by type of illness, treatment, medical condition, or
27 accident, ~~except for preexisting conditions as permitted by Section~~
28 ~~10708.~~

29 SEC. 26. Section 10708 of the Insurance Code is amended to
30 read:

31 10708. (a) (1) ~~Until January 1, 2014, preexisting condition~~
32 ~~provisions of~~ *December 31, 2013*, health benefit plans shall not
33 exclude coverage for a period beyond six months following the
34 individual's effective date of coverage and may only relate to
35 conditions for which medical advice, diagnosis, care, or treatment,
36 including the use of prescription medications, was recommended
37 by or received from a licensed health practitioner during the six
38 months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a health benefit plan offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(3) On or after January 1, 2014, preexisting condition provisions of a health benefit plan shall not exclude coverage following the individual's effective date of coverage for a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(b) (1) ~~Until January 1, 2014~~ *December 31, 2013*, a carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the subscriber or enrollee.

(2) On or after January 1, 2014, no waiting or affiliation period based on a preexisting condition, health status, or any other factor prohibited under subdivision (f) of Section 1357.03 shall be imposed. *A carrier may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees and if consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

(c) ~~Until January 1, 2014~~ *December 31, 2013*, in determining whether a preexisting condition provision or a waiting period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding health benefit plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any postenrollment or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person

1 becomes eligible for health coverage offered through employment
2 or sponsored by an employer within 180 days, exclusive of any
3 waiting or affiliation period, and applies for coverage under the
4 succeeding health benefit plan within the applicable enrollment
5 period.

6 (d) Group health benefit plans may not impose a preexisting
7 conditions exclusion to a condition relating to benefits for
8 pregnancy or maternity care.

9 (e) ~~A—(1) Until December 31, 2013,~~ a carrier providing
10 aggregate or specific stop loss coverage or any other assumption
11 of risk with reference to a health benefit plan shall provide that
12 the plan meets all requirements of this section concerning
13 preexisting condition provisions and waiting or affiliation periods.

14 (2) *On or after January 1, 2013, a carrier providing aggregate*
15 *or specific stoploss coverage or any other assumption of risk with*
16 *reference to a health benefit plan shall provide that the plan meets*
17 *all requirements of this section concerning waiting periods.*

18 (f) ~~Until January 1, 2014~~ *December 31, 2013,* in addition to the
19 preexisting condition exclusions authorized by subdivision (a) and
20 the waiting or affiliation period authorized by subdivision (b),
21 carriers providing coverage to a guaranteed association may impose
22 on employers or individuals purchasing coverage who would not
23 be eligible for guaranteed coverage if they were not purchasing
24 through the association a waiting or affiliation period, not to exceed
25 60 days, before the coverage issued subject to this chapter shall
26 become effective. During the waiting or affiliation period, the
27 carrier is not required to provide health care benefits and no
28 premiums shall be charged to the insured.

29 SEC. 27. Section 10709 of the Insurance Code is amended to
30 read:

31 10709. (a) (1) ~~Until January 1, 2014~~ *December 31, 2013,* no
32 health benefit plan may exclude late enrollees from coverage for
33 more than 12 months from the date of the late enrollee's application
34 for coverage. No premiums shall be charged to the late enrollee
35 until the exclusion period has ended.

36 (2) *On or after January 1, 2014,* no health benefit plan may
37 exclude late enrollees from coverage for more than 90 days from
38 the date of the late enrollees application for coverage. No premium
39 shall be charged to the late enrollee until the exclusion period has
40 ended.

1 (3) A health benefit plan may permit a waiting period of up to
2 90 days as a condition of enrollment if applied equally to all
3 full-time employees and if consistent with the federal Patient
4 Protection and Affordable Care Act (Public Law 111-148) and
5 any rules, regulations, or guidance issued consistent with that law.

6 (b) A carrier providing aggregate or specific stop loss coverage
7 or any other assumption of risk with reference to a health benefit
8 plan shall provide that the plan meets all requirements of this
9 section concerning late enrollees.

10 SEC. 28. Section 10714 of the Insurance Code is amended to
11 read:

12 10714. Premiums for benefit plan designs written, issued, or
13 administered by carriers on or after the effective date of this act,
14 shall be subject to the following requirements:

15 (a) (1) The premium for new business shall be determined for
16 an eligible employee in a particular risk category after applying a
17 risk adjustment factor to the carrier's standard employee risk rates.
18 The risk adjusted employee risk rate may not be more than 120
19 percent or less than 80 percent of the carrier's applicable standard
20 employee risk rate until July 1, 1996. Effective July 1, 1996, the
21 risk adjusted employee risk rate may not be more than 110 percent
22 or less than 90 percent. Effective January 1, 2014, ~~the risk~~
23 ~~adjustment factor shall be zero~~ *no risk adjustment factor shall be*
24 *used in the determination of rates.*

25 (2) The premium charged a small employer for new business
26 shall be equal to the sum of the risk adjusted employee risk rates.

27 (3) The standard employee risk rates applied to a small employer
28 for new business shall be in effect for no less than 12 months.

29 (b) (1) The premium for in force business shall be determined
30 for an eligible employee in a particular risk category after applying
31 a risk adjustment factor to the carrier's standard employee risk
32 rates. The risk adjusted employee risk rates may not be more than
33 120 percent or less than 80 percent of the carrier's applicable
34 standard employee risk rate until July 1, 1996. Effective July 1,
35 1996, the risk adjusted employee risk rate may not be more than
36 110 percent or less than 90 percent. The factor effective July 1,
37 1996, shall apply to in force business at the earlier of either the
38 time of renewal or July 1, 1997. Until January 1, 2014, the risk
39 adjustment factor applied to a small employer may not increase
40 by more than 10 percentage points from the risk adjustment factor

1 applied in the prior rating period. On or after January 1, 2014, ~~the~~
2 ~~risk adjustment factor shall be zero~~ *no risk adjustment factor shall*
3 *be used in the determination of rates.* The risk adjustment factor
4 for a small employer may not be modified more frequently than
5 every 12 months.

6 (2) The premium charged a small employer for in force business
7 shall be equal to the sum of the risk adjusted employee risk rates.
8 The standard employee risk rates shall be in effect for no less than
9 ~~six~~ 12 months.

10 (3) For a benefit plan design that a carrier has discontinued
11 offering, the risk adjustment factor applied to the standard
12 employee risk rates for the first rating period of the new benefit
13 plan design that the small employer elects to purchase shall be no
14 greater than the risk adjustment factor applied in the prior rating
15 period to the discontinued benefit plan design. However, the risk
16 adjusted employee rate may not be more than 120 percent or less
17 than 80 percent of the carrier's applicable standard employee risk
18 rate until July 1, 1996. Effective July 1, 1996, the risk adjusted
19 employee risk rate may not be more than 110 percent or less than
20 90 percent. The factor effective July 1, 1996, shall apply to in force
21 business at the earlier of either the time of renewal or July 1, 1997.
22 On or after January 1, 2014, ~~the risk adjustment factor shall be~~
23 ~~zero~~ *no risk adjustment factor shall be used in the determination*
24 *of rates.* The risk adjustment factor for a small employer may not
25 be modified more frequently than every 12 months.

26 (c) (1) For any small employer, a carrier may, with the consent
27 of the small employer, establish composite employee and
28 dependent rates for either new business or renewal of in force
29 business. The composite rates shall be determined as the average
30 of the risk adjusted employee risk rates for the small employer, as
31 determined in accordance with the requirements of subdivisions
32 (a) and (b). The sum of the composite rates so determined shall be
33 equal to the sum of the risk adjusted employee risk rates for the
34 small employer.

35 (2) The composite rates shall be used for all employees and
36 dependents covered throughout a rating period of ~~no less than six~~
37 ~~months, nor more than~~ 12 months, except that a carrier may reserve
38 the right to redetermine the composite rates if the enrollment under
39 the health benefit plan changes by more than a specified percentage
40 during the rating period. Any redetermination of the composite

1 rates shall be based on the same risk adjusted employee risk rates
2 used to determine the initial composite rates for the rating period.
3 If a carrier reserves the right to redetermine the rates and the
4 enrollment changes more than the specified percentage, the carrier
5 shall redetermine the composite rates if the redetermined rates
6 would result in a lower premium for the small employer. A carrier
7 reserving the right to redetermine the composite rates based upon
8 a change in enrollment shall use the same specified percentage to
9 measure that change with respect to all small employers electing
10 composite rates.

11 SEC. 29. Section 10716 of the Insurance Code is amended to
12 read:

13 10716. In connection with the offering for sale of any benefit
14 plan design to small employers:

15 Each carrier shall make a reasonable disclosure, as part of its
16 solicitation and sales materials, of the following:

17 (a) ~~Until January 1, 2014~~ *December 31, 2013*, the extent to
18 which the premium rates for a specified small employer are
19 established or adjusted in part based upon the actual or expected
20 variation in claims costs or actual or expected variation in health
21 conditions of the employees and dependents of the small employer.

22 (b) The provisions concerning the carrier's ability to change
23 premium rates and the factors other than claim experience which
24 affect changes in premium rates.

25 (c) Provisions relating to the guaranteed issue of policies and
26 contracts.

27 (d) ~~Until January 1, 2014~~ *December 31, 2013*, provisions relating
28 to the effect of any preexisting condition provision.

29 (e) Provisions relating to the small employer's right to apply
30 for any benefit plan design written, issued, or administered by the
31 carrier at the time of application for a new health benefit plan, or
32 at the time of renewal of a health benefit plan.

33 (f) The availability, upon request, of a listing of all the carrier's
34 benefit plan designs, including the rates for each benefit plan
35 design.

36 SEC. 30. Section 10717 of the Insurance Code is amended to
37 read:

38 10717. (a) No carrier shall provide or renew coverage subject
39 to this chapter until it has done all of the following:

1 (1) A statement has been filed with the commissioner listing all
2 of the carrier's benefit plan designs currently in force that are
3 offered or proposed to be offered for sale in this state, identified
4 by form number, and, if previously approved by the commissioner,
5 the date approved by the commissioner as well as, until ~~January~~
6 ~~1, 2014~~ *December 31, 2013*, the standard employee risk rate for
7 each risk category for each benefit plan design and the highest and
8 lowest risk adjustment factors that the carrier intends to use in
9 determining rates for each benefit plan design. When filing a new
10 benefit plan design pursuant to Section 10705, carriers may submit
11 both the policy form and, until ~~January 1, 2014~~ *December 31,*
12 *2013*, the standard employee risk rates for each risk category at
13 the same time.

14 (2) Until ~~January 1, 2014~~ *December 31, 2013*:

15 (A) Thirty days expires after that statement is filed without
16 written notice from the commissioner specifying the reasons for
17 his or her opinion that the carrier's risk categories or risk
18 adjustment factors do not comply with the requirements of this
19 chapter.

20 (B) Prior to that time the commissioner gives the carrier written
21 notice that the carrier's risk categories and risk adjustment factors
22 as filed comply with the requirements of this chapter.

23 (b) No carrier shall issue, deliver, renew, or revise a benefit plan
24 design lawfully provided pursuant to subdivision (a), and no carrier
25 shall change the risk categories, risk adjustment factors, or standard
26 employee risk rates for any benefit plan design until all of the
27 following requirements are met:

28 (1) The carrier files with the commissioner a statement of the
29 specific changes which the carrier proposes in the risk categories,
30 risk adjustment factors, or standard employee risk rates.

31 (2) Until ~~January 1, 2014~~ *December 31, 2013*:

32 (A) Thirty days expires after such statement is filed without
33 written notice from the commissioner specifying the reasons for
34 his or her opinion that the carrier's risk categories or risk
35 adjustment factors do not comply with the requirements of this
36 chapter.

37 (B) Prior to that time the commissioner gives the carrier written
38 notice that the carrier's risk categories and risk adjustment factors
39 as filed comply with the requirements of this chapter.

1 (c) Notwithstanding any provision to the contrary, until ~~January~~
2 ~~1, 2014~~ *December 31, 2013*, when a carrier is changing the standard
3 employee risk rates of a benefit plan design lawfully provided
4 under *subdivision* (a) or (b) ~~above~~ but is not changing the risk
5 categories or risk adjustment factors which have been previously
6 authorized, the carrier need not comply with the requirements of
7 paragraph (2) of subdivision (b), but instead shall submit the
8 revised standard employee risk rates for the benefit plan design
9 prior to offering or renewing the benefit plan design.

10 (d) When submitting filings under subdivision (a), (b), or (c),
11 a carrier may also file with the commissioner at the time of the
12 filings, until ~~January 1, 2014~~ *December 31, 2013*, a statement of
13 the standard employee risk rate for each risk category the carrier
14 intends to use for each month in the 12 months subsequent to the
15 date of the filing. Once the requirements of the applicable
16 subdivision (a), (b), or (c), have been met, these rates, until ~~January~~
17 ~~1, 2014~~ *December 31, 2013*, shall be used by the carrier for the
18 12-month period unless the carrier is otherwise informed by the
19 commissioner in his or her response to the filings submitted under
20 subdivision (a), (b), or (c), provided that any subsequent change
21 in the standard employee risk rates charged by the carrier which
22 differ from those previously filed with the commissioner must be
23 newly filed in accordance with this subdivision and provided that
24 the carrier does not change the risk categories or risk adjustment
25 factors for the benefit plan design.

26 (e) Until ~~January 1, 2014~~ *December 31, 2013*, if the
27 commissioner notifies the carrier, in writing, that the carrier's risk
28 categories or risk adjustment factors do not comply with the
29 requirements of this chapter, specifying the reasons for his or her
30 opinion, it is unlawful for the carrier, at any time after the receipt
31 of such notice, to utilize the noncomplying health benefit plan,
32 benefit plan design, risk categories, or risk adjustment factors in
33 conjunction with the health benefit plans or benefit plan designs
34 for which the filing was made.

35 (f) Each carrier shall maintain at its principal place of business
36 copies of all information required to be filed with the commissioner
37 pursuant to this section.

38 (g) Each carrier shall make the information and documentation
39 described in this section available to the commissioner upon
40 request.

1 (h) Nothing in this section shall be construed to permit the
2 commissioner to establish or approve the rates charged to
3 policyholders for health benefit plans.

4 (i) This section shall remain in effect only until January 1, 2014,
5 and as of that date is repealed, unless a later enacted statute, that
6 is enacted before January 1, 2014, deletes or extends that date.

7 SEC. 31. Section 10717 is added to the Insurance Code, to
8 read:

9 10717. (a) No carrier shall provide or renew coverage subject
10 to this chapter until it has filed a statement with the commissioner
11 listing all of the carrier's benefit plan designs currently in force
12 that are offered or proposed to be offered for sale in this state,
13 identified by form number, and, if previously approved by the
14 commissioner, and the date approved by the commissioner.

15 (b) Each carrier shall maintain at its principal place of business
16 copies of all information required to be filed with the commissioner
17 pursuant to this section.

18 (c) Each carrier shall make the information and documentation
19 described in this section available to the commissioner upon
20 request.

21 (d) Nothing in this section shall be construed to limit the
22 commissioner's authority to enforce the rating practices set forth
23 in this chapter.

24 (e) This section shall become operative on January 1, 2014.

25 SEC. 32. No reimbursement is required by this act pursuant to
26 Section 6 of Article XIII B of the California Constitution because
27 the only costs that may be incurred by a local agency or school
28 district will be incurred because this act creates a new crime or
29 infraction, eliminates a crime or infraction, or changes the penalty
30 for a crime or infraction, within the meaning of Section 17556 of
31 the Government Code, or changes the definition of a crime within
32 the meaning of Section 6 of Article XIII B of the California
33 Constitution.